VOPA INVESTIGATION REPORT

AN INVESTIGATION INTO THE NEGLECT OF SH

A 35 year-old male who was neglected by Danville-Pittsylvania Community Services

VOPA CASE # 02-0354

VIRGINIA OFFICE FOR PROTECTION AND ADVOCACY

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I. SUMMARY OF FACTS

SH was a long-time client of the Danville-Pittsyvlania Community Services Board ("DPCS") where, for almost six years, he had been diagnosed with and treated for Bipolar Disorder. On 18 October 2001, SH's doctor at DPCS ("Dr. A"[1]) told him that he did not have Bipolar Disorder and abruptly discontinued his antipsychotic medication. Dr. A based the change in diagnosis on his contention that SH's Bipolar Disorder was not "confirmed" – that Dr. A had never witnessed SH display symptoms consistent with Bipolar Disorder and SH's records did not reflect any professionals reporting that they had witnessed him display such symptoms. Dr. A made these statements despite ample evidence in SH's record indicating that he had Bipolar Disorder and despite Dr. A's having testified at a hearing on 14 February 2001, that, based upon his own observations and his review of SH's medical records, SH was psychotic, hypomanic, delusional, suffering from a mental illness, and likely to decompensate and require hospitalization if he did not take antipsychotic medication. Shortly after Dr. A discontinued SH's antipsychotic medication, SH decompensated and required hospitalization, just as predicted by Dr. A in his testimony.

II. SUMMARY OF FINDINGS

DPCS neglected SH by denying him needed care and treatment, resulting in his decompensation and hospitalization. SH was the victim of a doctor who used an improper diagnostic method to reach an incorrect diagnosis and a facility that did not adequately supervise its doctors.

DPCS, through Dr. A, erroneously found that SH did not have Bipolar Disorder after failing to review or ignoring SH's medical and other records (including Dr. A's own testimony)

[1] DPCS staff refused to allow their names to be published with this report.

indicating that SH had Bipolar Disorder and displayed symptoms of it. DPCS also failed and/or refused to even attempt to contact other doctors and professionals who had found SH to have Bipolar Disorder and witnessed him display symptoms of it. DCPS then improperly and abruptly discontinued SH's antipsychotic medication. As a result of DPCS's improper treatment, SH decompensated and was hospitalized.

DPCS did not have adequate supervisory mechanisms in place to review and oversee Dr. A's (or any of its other doctors') work. No one at DPCS could or would disagree with or contradict the diagnostic and treatment decisions made by Dr. A. As a result, DPCS had no way to ensure that its doctors provided quality care and treatment to its patients, and, when, as in this case, its doctors provided improper care and treatment, DPCS had no way to recognize or correct the situation.

III. HISTORY OF INVESTIGATION

The Virginia Office for Protection and Advocacy (VOPA) conducted this investigation pursuant to the authority granted to it by the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. §10801, *et seq.,* the Virginians with Disabilities Act, Code of Virginia §51.5-1, *et seq.,* and all other applicable Virginia and federal law.

In the course of this investigation, VOPA:

A. reviewed SH's medical records;

B. conducted interviews with SH and people familiar with his care and treatment;

C. conducted interviews with DPCS managerial staff (including the Executive Director, Mental Health Director, and Coordinator of Case Management), DPCS staff who worked directly with SH (including his Counselor and Case Manager), and two DPCS doctors (including Dr. A) who treated SH; and

D. engaged two doctors as experts to review SH's care. The report of Dr. Llewellyn B. Bigelow, M.D. is attached hereto as Exhibit A.[2] The report of Ronald J. Koshes, M.D. is attached hereto as Exhibit B.

On 3 June 2003, draft copies of this report were sent to DPCS and SH. Each party was given the opportunity to submit a response and told that its response would be published with this report if it was received by 20 June 2003.

Instead of responding to the report, DPCS, first demanded that VOPA not publish its report and threatened, if VOPA did publish, to make negative statements about the VOPA staff person who conducted the investigation. When VOPA stated its intention to publish the report, DPCS filed a lawsuit in the Circuit Court for the City of Danville, asking that the Court forbid VOPA from publishing the report. In the lawsuit, DPCS admitted that VOPA's report had found that DPCS neglected the consumer. DPCS also unlawfully disclosed the consumer's name and made numerous false and meritless statements about VOPA, its staff, and the investigation. VOPA responded by requesting that the United States District Court for the Western District of Virginia take jurisdiction over the case. VOPA informed DPCS that it would file a Motion to Dismiss the lawsuit and provided a draft copy of the Motion to DPCS. In response, DPCS filed a Motion to Dismiss its own lawsuit and submitted a new response to the report. The District Court, on 27 August 2003, declined to hear the case and remanded it back to the Circuit Court for the City of Danville. DPCS then asked the Circuit Court to dismiss its lawsuit. On 9 September 2003, DPCS's request was granted and its case was dismissed.

[2] VOPA's draft report did not cite to Dr. Bigelow's findings. Rather, the draft report only cited to and quoted Dr. Koshes's opinion. As shall be more fully stated herein (see p. 34), DPCS has criticized VOPA for not including Dr. Bigelow's opinion in its draft report. Therefore, VOPA includes and cites to Dr. Bigelow's findings in this report.

Attached as Exhibit C is DPCS's latest response to VOPA's report. VOPA has chosen to excise certain portions of the response as they contain false and defamatory statements. VOPA will not publish such statements as doing so will not only cause harm to the subject of the statements but may, thereby, expose VOPA to liability. VOPA's reply to DPCS's response is found at page 36 of this report.

VOPA has received permission from SH to publish this report and make public details about his treatment and neglect by DPCS.

IV. FACTS

A. Danville-Pittsylvania Community Services

DPCS is a Community Services Board (CSB) founded and operated pursuant to Code of Virginia §37.1-194, *et seq.* Community Services Boards "function as the single point of entry into the publicly funded mental health . . . system." (Code of Virginia §37.1-197.1)

CSBs have the authority to "enter into contracts with other providers for the rendition or operation of services or facilities." (Code of Virginia §37.1-197) Pursuant to this authority, DPCS contracts with psychiatrists to render mental health services to its clients.

DPCS also provides community-based mental health services including 24-hour emergency services, mental health care and treatment, psychosocial rehabilitation, in-home services, and case management.

B. Chronology of Events

The following Chronology of Events is taken from SH's medical records, his records from DPCS, and from interviews with SH and others. The intent of the Chronology is to document significant events in SH's medical and mental health treatment from August 1995

through February 2002. It is not intended to document every medical report or life event during that time.

1. August 1995 – July 1996

During this period, SH had his first contacts with DPCS. This period is notable for DPCS's initial recognition of his psychotic symptoms and the progression of SH's diagnosis from Psychotic Disorder (Not Otherwise Specified) to Bipolar Disorder.

25 August 1995
SH presents at DPCS Emergency Services Unit. DPCS finds him to be "unable to maintain concentration – Extreme religious delusions – hallucinations about being Jesus and carrying own cross – hearing voices from England calling him. Disoriented to time and situation... Ritualistic washing – of sins from his body."

SH is prescreened to determine whether he should be hospitalized. DPCS finds him to have delusions and that he is disoriented, agitated, grandiose, has hallucinations, impaired impulse control, bizarre behavior, loose associations, impaired judgment, sleep disturbance, flight of ideas, and pressured speech. As a result, he is hospitalized.

2 October 1995
DPCS does an intake assessment after SH was released from Central State Hospital. DPCS states "The focus of treatment will be upon helping the client deal with [his] psychotic disorder."

26 October 1995
DPCS does a psychiatric evaluation of SH. The doctor's diagnosis is: "Axis I – rule out Bipolar Disorder, manic by history; rule out schizoaffective disorder, bipolar type. Axis II – Deferred. Axis III – rule out temporal lobe dysfunction."

9 January 1996
DPCS does its quarterly review of SH's case. DPCS states that SH has "been under significant stress prior to this hospitalization and was described as grandiose, delusional, and paranoid with some ritualistic behavior. . . . The undersigned feels strongly that a bipolar disorder in this client's case needs to be ruled out in treatment."

April 1996
DPCS does its quarterly review of SH's case. The reviewer states "At the time of this writing, the client has been readmitted to SVMHI for reoccurrence of the psychosis which originally hospitalized him. . . .The client was admitted to Southern Virginia as noted above due to non-compliance with his medicine and becoming affectively labile and showing evident signs of psychosis."

23 April 1996
SH is seen by DPCS Emergency Outreach Services. DPCS states that SH was observed by his family with "lose associations, pressured speech, increase in religiosity, increased psychomotor agitation." DPCS notes that those "symptoms also evident in interview."

24 April 1996
SH is seen as a follow up to the evaluation done on 23 April 1996. DPCS finds "Cl. Affect is labile and psychosis is still evident."

SH is also evaluated by a doctor at Southern Virginia Mental Health Institute. The doctor states "he has an almost permanent smile on his face and he glances upward and to his left frequently as though he is hearing voices. . . . At times he inclines his head suggesting that he is hearing something which the undersigned is not. . . . From observation, it appears this patient is experiencing auditory hallucinations."

10 May 1996
DPCS performs an Intake Supplement. The DPCS staff person states "the client returns to DMNHD from a second hospitalization for manic depressive disorder, manic episode most recent with psychotic features." DPCS revises SH's diagnosis to: "Axis I: 296.44, Bipolar I Disorder, Most recent episodes manic, with psychotic features."

July 1996
DPCS does its quarterly review of SH's case. DPCS states "The treatment goals have been redefined as follows: To manage his Bipolar symptoms through chemotherapy and psychotherapy with the objective of focusing on his newly claimed priorities. . . The client is aware of his diagnosis of Bipolar Disorder with Manic and Psychotic Features."

2. August 1996 – August 1997

During this period, SH was diagnosed with and treated for Bipolar Disorder and prescribed antipsychotic medications. Through most of this period, he, apparently, did well but signs of decompensation are noted throughout. Then, in July 1997, SH stopped taking his antipsychotic medication, decompensated, and was hospitalized.

9 August 1996
DPCS reviews SH's case. On its "Objectives and Plans" form, DPCS notes its treatment goal as "To manage bipolar symptoms." In its "Summary of Assessment" DPCS notes "Client coming to terms with his life style changes created by illness (Bi-polar d/o)"

October 1996
DPCS does its quarterly review of SH's case. DPCS notes "In the last few weeks, since returning to school, the client has begun to slip. . . The client's concern is that he not relapse and fall back into old ways which includes bipolar symptoms.

10 October 1996
SH is seen by a DPCS doctor, who notes that he "reports subjective satisfaction . . . and denied any overt psychological symptoms as such. He does have some tenuous logical [sic]. . ."

7 January 1997
SH is seen by a DPCS doctor who notes that "I am a bit concerned about his pursuit of a pagan religion WICCA potentially in conflict with his Christian parents. He is conceding to erratic compliance on Haldol and claims better compliance with his other medications. I'm not sure how this could be, but at any rate he is willing to continue his medications without a change."

25 March 1997
SH is seen by a DPCS doctor, who notes that he was "seen earlier than previous scheduled with concerns that he has been quite withdrawn, passive and indifferent about work. In fact, he describes some symptoms of psychomotor retardation and depression, but none of any definitive and pervasive psychosis."

April 1997
DPCS does its quarterly review of SH's case. DPCS states "The client has been erratic in therapy; he failed the last scheduled appointment. . . There are some emerging and as yet unidentified issues.

24 April 1997
SH is seen by a DPCS doctor, who notes that he "is clinically stable without any signs of any overt decompensation. He continues to refer to some eccentric thought processes. . . ."

July 1997
DPCS does its quarterly review of SH's case. DPCS states "The client still appears to undercut himself and to shoot himself in the foot by his actions. . . At one point it appeared therapy was moving toward termination. There now seems to be a shift from maintenance to self-awareness and self-management of the client's behavior."

9 July 1997
SH presents at DPCS Emergency Services. DPCS notes that he is complaining of depression and states that his "Thought content is suicide with a plan to shoot self or hang self. . . Cl reports he doesn't care if he eats, sleeps, works or dies."

DPCS performs a preadmission screening. DPCS's clinical assessment notes that SH has poor self care, impaired impulse control, impaired judgment, appetite disturbance, sleep disturbance, and is withdrawn, depressed, and has suicidal ideation. DPCS noted that he had not taken his medication in three weeks. As a result, SH is hospitalized.

3. August 1997 – April 1998

During this period, SH continued to be diagnosed with and treated for Bipolar Disorder. He continued to be prescribed antipsychotic medications. Throughout this period, SH

showed signs of his disability. In April 1998, he stopped taking his antipsychotic medications, decompensated, and was hospitalized.

12 August 1997
SH sees a DPCS doctor who states that he "was recently discharged from Southern Virginia Mental Health Institute after a period of five weeks of hospitalization in context of increasing anxiety and psychosis. . . ."

10 September 1997
DPCS reviews SH's case. DPCS states "Cl struggles with adjusting to living with himself with his bi-polar [disorder]. . . .Goal: in next three months, cl to take specific measurable and addressable actions to become responsible for his life and the management of his bi-polar [disorder]."

23 September 1997
SH sees a DPCS doctor, who notes that he "came in a bit late as he described his struggle to get out of bed and a general tendency to be slow in psychomotor spontaneity and being relatively indifferent at times. . . Overall, SH maintains stability as far as any overt mania and psychosis is concerned. On the other hand, he is quite low in terms of sustained concentration, attention, motivation, and task performance."

8 October 1997
SH undergoes a mental health evaluation. DPCS finds his mood and affect to be "slightly manic, but unremarkable."

5 February 1998
SH sees a DPCS doctor, who states that he "is describing significant anxiety in context [of a decision regarding his family]. . . ."

19 March 1998
SH sees a DPCS doctor, who states that he is "meek, pleasant and asymptomatic. . . He does have a certain eccentricity to his thinking"

27 April 1998
SH is seen by DPCS Emergency Services. DPCS finds him to have a "preoccupation with death" and identifies "Psychotic-Like Behavior" including poor personal hygiene, suspiciousness, irritability, poor judgment, and hallucinations. SH's thought content is described as "suicidal" and "hallucinations."

The DPCS prescreener's Clinical Assessment states that SH suffers from paranoia, poor self care, hallucinations, impaired impulse control, bizarre behavior, impaired judgment, sleep disturbance, and pressured speech. DPCS states "Cl reporting hallucinations telling him not to take meds, fears someone is after him." DPCS finds that SH is a danger to himself or others and in need of hospitalization.

4. June 1998 – July 2000

During this period, SH continued to be diagnosed with and treated for Bipolar Disorder. He continued to be prescribed antipsychotic medication. SH showed symptoms of his disability throughout this period but was able to avoid hospitalization.

2 June 1998
SH sees a DPCS doctor, who notes that he "was recently discharged from Southern Virginia Mental Health Institute on a regimen of several medications. . . ."

11 June 1998
SH sees a DPCS doctor, who notes that he "is describing significant psychomotor slowing and sedation, lack of energy, and some depression in context of his recent discharge from the hospital on a regimen of Zyprexa (10 m.g.) q.h.s. increased from (5 mg) q.h.s. after he became agitated, intoxicated and apparently manicy. . . ."

7 July 1998
SH sees a DPCS doctor, who notes that he "is describing relatively low moods this morning. . . . He denies any signs indicative of any pervasive melancholia, any psychosis or any other signs of any gross clinical decompensation."

17 September 1998
DPCS reviews SH's Treatment Plan. The Plan identifies his "Problem" as "Bi-Polar [symptoms]." His Service Plan states "Therapist to assist cl. in maintaining stability via providing supportive environment for cl. to address issues, problems and bi-polar [symptoms]."

17 March 1999
SH consults with DPCS Emergency Services. He "reports very poor follow through with 2nd semester in college. . . . Virtually dropped out of classes. . ."

23 March 1999
SH sees a DPCS doctor, who notes that SH has reduced "some of his medications with it being unclear the logic of this issue. It is of note also that later the client describes himself as 'sleeping all the time because I have no life'. . . This may actually represent more of the client's perceptions and somewhat more of a personality structure issue. . ."

23 April 1999
SH sees a DPCS doctor who notes that he "acknowledges for a period of time he stopped using medications, began to get 'spacey,' had increasing difficulty at school. He is today requesting medical leave to 'protect his grades and all the work he's done.' It is of note that the client is anticipating going to an AMI conference this weekend and reports some anxiety related to that. . . .Assessment: The client stopped taking medications for a period of time, began to decompensate and restarted his medication, with his now reported improved emotional conditions."

14 October 1999
SH sees a DPCS doctor who notes that "he continues to have auditory hallucinations, and he copes with them by doing meditation and using relaxation tapes using alpha waves. He denies any visual hallucinations. He states his mood continues to fluctuate quite wildly. Currently he is very upbeat and positive. He denies any suicidal or homicidal ideation since the last visit. He is sleeping and eating well."

11 November 1999
SH sees a DPCS doctor, who states that he "is very happy on the Seroquel...He feels his auditory hallucinations, which he has chronically, have actually decreased on the Seroquel…."

2 March 2000
SH sees a DPCS doctor who notes "Assessment: Diagnosis has centered around a bipolar disorder and substance abuse. There are no indications of any acute decompensation as the client appears psychiatrically stable at this time."

8 March 2000
DPCS reviews SH's Individual Service Plan. Plan states his diagnosis as "Ia (296.44) Bipolar [disorder]. Mixed with Psychotic Features. . . ."

31 May 2000
DPCS reviews SH's Individual Service Plan. The Plan states "Summary of Assessment: Cl is an established consumer with a [diagnosis] of Bipolar D/O. . . . Long Term Goal: Cl to maintain control of [symptoms] such as mania, depression, and agitation for 1 year without rehospitalization."

17 July 2000
SH sees a DPCS doctor who states that he "reports that he has been doing very well. . . . Assessment: Bipolar disorder and a history of substance abuse."

5. September 2000 – November 2000

During this period, SH continued to be diagnosed with and treated for Bipolar Disorder. He continued to be prescribed antipsychotic medication. SH's symptoms increased during this period. In October 2000, after he stopped taking his antipsychotic medications, he decompensated and was hospitalized.

17 September 2000
SH contacts DPCS Emergency Services. He relates an increase in symptomology, hallucinations, and racing thoughts. DPCS states, "Allowed client to ventilate and offered support."

3 October 2000
SH contacts DPCS Emergency Services. DPCS states that he was "ruminating on racing thoughts." DPCS recommends that he "ground" himself through chores, schedule, lists, etc. to control racing thoughts.

4 October 2000
SH is assessed by DPCS Emergency Services. DPCS notes that he "laughs often during speech" and that his affect is inconsistent with his mood. DPCS also notes that SH is experiencing visual hallucinations and that he states that he is "losing control," "not being able to maintain," "I can see it coming," and "I am sending up the red flag." He is sent for evaluation for hospitalization.

SH is then seen by a DPCS doctor who notes that he stated that he was feeling like he was going to "explode" that he was "losing control." "He says he stopped taking his medications, specifically the Seroquel, approximately two weeks ago, and told emergency services clinician that 'I can see it coming' and saying things such as 'tick, tick, tick, boom' and he was also wearing a T-shirt that said Bomb Squad on it. . . .His concentration and attention are poor….There is much hesitation between my questions and his responses as if he is having a difficult time understanding what I am asking or how to respond. . . ." As a result, SH is hospitalized.

17 October 2000
SH is seen by Dr. A of DPCS. Dr. A notes that SH "reports that he did experience auditory hallucinations several weeks ago… He did inform me that two or three weeks ago he had this bad feeling regarding what was happening in the Middle East. He stated that he has seen crows and that he felt this was an ominous sign. He went further into his delusions indicating that he believes he is a descendent of the Middle East and that Middle East blood runs in him. This he takes from the scripture, believing that all people in the world are related to each other. . . .He denies any suicidal or homicidal ideation. . . .Diagnosis: Axis I-Bipolar Affective Disorder, history of substance abuse. Axis II – None."

28 November 2000
SH sees Dr. A of DPCS. Dr. A reports that SH is "doing well since restarting his medication….his delusions are not as extreme as the last time he was here. Diagnosis: Axis I – Bipolar Affective Disorder, history of substance abuse. Axis II – none."

6. February 2001

During this month, SH was diagnosed with and treated for Bipolar Disorder. He was prescribed antipsychotic medication. During this month, SH decompensated and was hospitalized. Dr. A of DPCS testified at his commitment hearing, stating that SH was psychotic and unable to care for himself.

8 February 2001
SH contacts DPCS Emergency Services. He reports "increasing anxiety to the point of missing some of his classes at [Danville Community College]. . . ."

11 February 2001
SH contacts DPCS Emergency Services. DPCS reports "Client verbalizing upset due to grandmother having the police follow him around town. . . Angry. A series of bashing of CSB – 'they've done me wrong. I don't even have adequate funds to live off.' A series of bashing the Danville police department and the city of Danville itself. . . Client paranoid. Mood labile."

12 February 2001
SH is referred to DPCS Emergency Services Assessment. DPCS states that SH reported that he "couldn't take it anymore and. . . felt . . . persecuted by Danville and needed to leave. . . Believes he predicted a presidential assassination attempt also believes he performed an incantation of the devil who he has named and will be arriving any day from New Orleans." DPCS notes his behavior as "resistive" and "sarcastic." DPCS describes his thought form as "loose associations" and "flight of ideas," his speech as "rapid" and "pressured," his thought content as "Hopelessness," "Helplessness," "Idea of reference," "Paranoia," "Superficial," and "Delusions (paranoid. . . grandiose)." DPCS notes that he has "impaired impulse control" and has an "inability to care for self."

DPCS screens SH for admission to the hospital. DPCS notes "cl walks into the ER this early am asking to see a psychiatrist . . . in a discussion with ER counselor insists that he predicted the attempted assassination on the president. . . ." DPCS notes, "cl reports belie that he has called up a demon called 'Asmodius' in a pagan ritual and says the being is coming here from New Orleans." SH's mental status was noted as "hypomanic," his speech as "pressured," his mood as "anxious" and "fearful," his thought content as "delusions," "ideas of grandiose," "paranoid," and his thought process as "loose associations" and "flight of ideas." As a result, SH is hospitalized.

SH then saw Dr. R at Southern Virginia Mental Health Institute. Dr. R. states, "This is a patient with multiple hospitalizations with diagnosis ranging from Bipolar Disorder to Schizoaffective, Personality Disorder, also Alcohol, Marijuana and Cocaine Abuse. He is admitted for unclear reasons this time. . . . However, to me the patient does not appear psychotic, and from his attitude I feel that he is trying to look as unusual in his thinking as possible. . . For the time being, I would defer his primary diagnosis, and I would even consider stopping all his medications and running some psychological testing."

14 February 2001
At SH's Commitment Hearing, Dr. A testifies that SH should remain in the hospital because he is unable to care for himself.

Dr. A testified:

> From prior contact with SH, he has exhibited, and from review [of the] record, displayed symptoms consistent with mania in the past as well as hypomania, as well as delusions, bizarre ideation in my contacts with him. . . .
>
> In viewing the records and documents here and at the hospital he appears to be delusional. He also appears to be somewhat hypomanic and grandiose in his delusions. I do agree with the fact that he does need to be in the hospital based on his inability to care for himself in the sense that, due to the nature of his illness, with his being manic, if he does continue in the course of his illness without adequate treatment, he does face the risk of going into manic exhaustion and eventually collapse.

Dr. A was then questioned by SH's attorney.

> Attorney: Do you think [SH] is psychotic?
> Dr. A: Yes.
>
> Attorney: Would it surprise you that the treating psychiatrist at Southern Virginia [Mental Health Institute] said he is not psychotic?
> Dr. A: Yes.
>
> Attorney: How do you explain the difference between your opinion and Southern Virginia's?
> Dr. A: I've had the pleasure of reviewing prior records at community services [DPCS]. I've seen him delusional before and that's my opinion that he does have mental illness.
>
> Attorney: But do you think he's psychotic now?
> Dr. A: Yes. . . .
>
> Attorney: Your prediction of unable to care for self is based on your prediction of the course of events that will happen, a continued worsening of his manic condition?
> Dr. A: Eventually it will happen if he is noncompliant with his medication and continues to be manic.
>
> Attorney: If he becomes noncompliant, the possibility is he will become hypomanic?
> Dr. A: No, no, no. What I'm saying is he appears at this time to be hypomanic and delusional and in the event that he is noncompliant with his medication the possibility does exist, if he continues on that course, he will eventually become manic.

26 February 2001
SH sees Dr. A at DPCS. Dr. A makes two separate, seemingly inconsistent, reports.

In the first report, Dr. A states "This is a white Caucasian male who was recently discharged from SVMHI after a brief hospitalization. His symptomology was consistent with Hypomanic state. He indicated that he was experiencing auditory hallucinations, racing thoughts, and his mood was somewhat elevated, easily agitated and extremely irritable. One is referred to the chart for a more complete description of client's history and issues related to his diagnosis. My signature on the ISP [Individual Service Plan] indicates my agreement with the treatment plan." At the time Dr. A made this report, SH's Individual Service Plan indicated that he had Bipolar Disorder.

In the second report of that date, Dr. A states that SH "was recently discharged from Southern Virginia Mental Health Institute. Discharge summary indicates that client has no Axis I diagnosis and Axis II is Personality Disorder, NOS. I discussed with [Dr. R] from Southern Virginia who indicates that she believes the medication is to help with his personality problems. …He denies any current auditory, visual or tactile hallucinations or delusions. . . " Dr. A then changed SH's diagnosis from "Bipolar Affective Disorder" to "Bipolar Affective Disorder, by history."

7. April 2001 – December 2001

During this period, SH was diagnosed and treated for "Bipolar Affective Disorder, by history." He was prescribed antipsychotic medication until October 2001, when it was discontinued.

26 April 2001
SH sees Dr. A at DPCS. Dr. A notes that SH "called Emergency Services last week and reported that he was feeling like hurting himself. He was assessed and felt not to be a threat to himself.…The client states that he has been compliant with his medications although the records indicate that he has not picked up meds here since his discharge…."

28 July 2001
SH is seen by DPCS Emergency Services. DPCS noted his level of consciousness as "hypervigilent," his speech as "pressured," his thought form as "flight of ideas," and his thought content as "Hallucinations (. . .visual)" and "Delusions (. . . grandiose. . . bizarre)." His insight and judgment were noted as "poor," and his risk assessment was noted as "impaired impulse control" and "inability to care for (self. . .)" As a result, SH was hospitalized.

At Danville Regional Medical Center, SH was evaluated, and it was noted that he complained of "hearing voices" "visual hallucinations." The hospital found him to be "Psychotic." A doctor called in for a consult found him "very psychotic, very delusional, also paranoid, over-anxious and overwhelmed. Currently, the patient is frightened and unable to function."

30 July 2001
SH was evaluated by DPCS Emergency Services at Danville Regional Medical Center after he requested to be discharged. DPCS noted his level of consciousness as "disoriented to time/date," his affect as "labile" and "anxious," his thought form as "loose associations" and his thought content as "bizarre ideation," "confabulation," and "delusions (paranoid. . . grandiose)." DPCS states "On interview, the client is superficially cooperative. He continues to make bizarre remarks about the CIA and the drug activity in Danville."

DPCS further noted that "Client came into E.R. on 7/28/01 requesting voluntary admission. According to records the client reports not taking his medications for 2 weeks. The client presented as delusional, making statements about the CIA being in Egypt and India. He was also admitting to auditory hallucinations and requested a hospitalization. On this date, 7/30/01, the client requested to leave and the psychiatrist felt the client was not ready." DPCS noted his thought content as "delusions," "ideas of grandiose," and "paranoid," his thought process as "loose associations," his Perception/Sensorium as "hallucinations." DPCS states, "Client loose and delusional at times during the conversation. He was cooperative during the interview but was hard to redirect from delusion r/t CIA. He admits that some of his thoughts may be delusional."

September 2001
SH sells nearly everything he owns and moves to Pittsburgh, Pennsylvania, to enter culinary school. Shortly after arriving, he decompensated and was hospitalized. The hospital diagnosed him as having Schizoaffective Disorder, prescribed antipsychotic medication and released him. Subsequently, SH returned to Danville and again sought service at DPCS.

18 October 2001
SH sees Dr. A at DPCS. Dr. A notes that SH "sold everything he owned in Danville and applied to culinary school in Pittsburgh and moved up there. Apparently things weren't as well as he expected….He was admitted to Allegheny Hospital. He told them that he had command hallucinations to jump off a bridge and that he was manic, although the note is not clear whether that but (sic) was an old statement he had made in the past. Today he indicates that he was both depressed and manic, however working through the issues he indicated or agree with me that whenever he gets upset is when he tells people he is not manic to get into the hospital…He was quite upset today when I told him I believed that he did not have Bipolar Disorder and that I was stopping his medication." Dr. A discontinued SH's antipsychotic medication.

23 October 2001
SH requests a "second opinion" after Dr. A told him that he did not have Bipolar Disorder and discontinued his antipsychotic medication. DPCS arranges for SH to see Dr. R, who had previously examined SH in February, 2001. Dr. R notes that SH described hallucinations, delusions, and actions "which could have been suggestive of responding to internal stimuli" but found him to be "evasive." Dr. R. stated "I would suggest having the client tapered off his medications while followed clinically, maybe on a weekly basis to start with, in order to notice any kind of decompensation." This recommendation is not implemented.

1 December 2001
SH is admitted to the Psychiatric Unit of Danville Regional Medical Center. The hospital report states "He has had frequent recurrence of hallucinations whenever he is not compliant with his medication. At this time he is depressed with significant feelings that he is in a dark place and feels that he has no way out. "The patient is extremely depressed with psychomotor retardation, preoccupied and says he is hearing voices. . . .Judgment and insight are impaired from psychosis." The hospital re-prescribes antipsychotic medications.

8. January 2002 – February 2002

2 January 2002
Dr. R of DPCS prescribes antipsychotic medication for SH.

1 February 2002
SH informs DPCS that he will be receiving treatment from the Piedmont Community Services Board in Martinsville, Virginia. Piedmont Community Services Board provides treatment for SH's mental illness and prescribes antipsychotic medication.

V. FINDINGS

A. Definitions

1. Definition of "Facility" for Purposes of PAIMI Act

> The term "facilities" may include, but need not be limited to, hospitals, nursing homes, community facilities for individuals with mental illness, board and care homes, homeless shelters, and jails and prisons. (42 U.S.C. §10182(3))

2. Definition of "Provider" for Purposes of Virginia State Law

> "Provider" means any person, entity or organization, excluding an agency of the federal government by whatever name or designation, that provides services to persons with mental illness, mental retardation or substance addiction or abuse. . . . Such person, entity or organization shall include a. . . community services board as defined in §37.1-194.1. (Code of Virginia §37.1-179)

3. Definition of "Neglect" for Purposes of the PAIMI Act

> The term "neglect" means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to a [sic] individual with mental illness or which placed a [sic] individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment

plan for a individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to a [sic] individual with mental illness, or the failure to provide a safe environment for a [sic] individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff. (42 U.S.C. §10802(5))

4. Definition of "Neglect" for Purposes of Virginia State Law

"Neglect" means failure by an individual, program, or facility responsible for providing services to provide nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation, or substance abuse. (Code of Virginia §37.1-179)

B. Experts' Findings

1. Dr. Bigelow's Findings

In June 2002, Dr. Llewellyn B. Bigelow, reviewed SH's treatment and found:

To make a long story short, the change in diagnosis is so inappropriate as to make one wonder how and why any professional might change his diagnosis and, apparently, justify removing a critical component of his treatment, the antipsychotic drug risperdal. . . .

I reviewed with some care a consultative note by [Dr. R] dated October 23, 2001 – well after the peculiar change in diagnosis by [Dr. A]. My understanding is that [Dr. R] works at the same facility as [Dr. A] and can scarcely be considered to be an independent outside person. It contains so many inaccurate distortions of current diagnostic terminology and of [SH's] history that I will not enumerate them here. . . .

Finally, I would note that the deliberate withdrawal of treatment from [SH] and the unexplainable change in diagnosis probably, in my opinion, must expose both [Drs. A and R] and [DPCS] to a significant malpractice suit for their actions. . . .

2. Dr. Koshes's Findings

Subsequently, Dr. Ronald J. Koshes reviewed this matter and the transcripts of interviews of DPCS staff. Dr. Koshes found:

[SH's] care was not appropriate while he was a patient cared for by [Dr. A] at the Danville-Pittsylvania Community Services Board. To wit:

1. The clinical record indicated a clear history of Bipolar/ Schizoaffective Disorder with multiple hospitalizations for symptoms of these illnesses and clear documentation by several psychiatrists that SH's symptoms were not fabricated, nor the result of a Personality Disorder. [Dr. A] stated that he did not review the previous clinical records of SH, nor did he think it was necessary, resulting in a faulty formulation of the case and a poorly conceived treatment plan. This violated accepted standards of psychiatric care.

2. Fail[ing] to appreciate the significance of SH's past history, [Dr. A] discontinued the antipsychotic medication without either tapering the medication or providing SH with guidance on what to do should symptoms re-occur. This resulted in the hospitalization of SH for symptoms of his mental illness. This indicated a failure to provide an adequate level of care, and violated accepted standards of psychiatric care.

Dr. Koshes further found:

> An additional and related finding from this review is that there was no process for medical supervision of the psychiatrists employed at the Danville-Pittsylvania Community Services Board. A non-psychiatrist, non-medical doctor cannot medically supervise a psychiatrist. Presenting the clinical questions [Dr. A] had to this medical supervisor would likely have resulted in a different outcome.

Finally, Dr. Koshes found that DPCS and Dr. A's "approach to diagnosis and treatment most likely led to SH's subsequent decompensation and hospitalization."

C. VOPA's Findings

Based on the expert reports and the documents, interviews, and other evidence reviewed in this investigation, VOPA finds that SH was the victim of neglect by DPCS, as that term is defined in the PAIMI Act and Regulations.

DPCS's neglect of SH occurred in four distinct respects. Each resulted in SH being denied needed treatment and put at risk of severe injury, leading to his decompensation and hospitalization:

(1) DPCS misdiagnosed SH when it decided that he did not have Bipolar Disorder;[3]

(2) DPCS used an improper diagnostic method in making the determination that SH did not have Bipolar Disorder;

(3) DPCS improperly discontinued SH's antipsychotic medication; and

(4) DPCS did not adequately supervise its doctors or provide appropriate oversight to ensure that proper diagnoses and treatment were provided to SH.

1. DPCS is a "Facility" for the Purposes of the PAIMI Act and a "Provider" for Purposes of Virginia State Law

DPCS provides mental health services including emergency services, case management, inpatient services, psychosocial rehabilitation, in-home services, and mental-health care and treatment. It is, therefore, a "community facility" and meets the definition of a "Facility" for purposes of the PAIMI Act. Additionally, by the express terms of Virginia State law, DPCS is a "Provider."

Therefore, a failure by DPCS to provide needed treatment to SH, putting him at risk of injury, constitutes neglect for the purposes of the PAIMI Act and Virginia State law.

2. DPCS Incorrectly Found that SH Did Not Have Bipolar Disorder

First, VOPA finds that DPCS neglected SH when Dr. A erroneously found that SH did not have Bipolar Disorder and discontinued his antipsychotic medication, resulting in SH's decompensation and hospitalization.

[3] SH has been diagnosed, at different times, with different psychotic disorders, including Schizoaffective Disorder, Psychotic Disorder Not Otherwise Specified, and Bipolar Disorder. Because SH's prevailing diagnosis during his treatment by DPCS was Bipolar Disorder, his mental illness will be referred to, throughout this report, as Bipolar Disorder.

In his interview with VOPA, Dr. A stated that he determined that SH did not have Bipolar Disorder and discontinued his antipsychotic medication because he could not "confirm" that SH had Bipolar Disorder. Specifically, Dr. A stated that he had never observed SH to display symptoms of or consistent with Bipolar Disorder[4] and that there was no documentation in SH's records or history indicating that any other professional had observed such symptoms.

Dr. A did not dispute that SH had often described symptoms that would indicate that he had Bipolar Disorder. However, Dr. A maintained that SH's symptoms were self-reported and, as such, did not provide confirmation that he actually suffered from the symptoms he described. For example, Dr. A stated:

> I'm sorry, it's like saying, you see a guy and you see he has the flu so he has the flu. It's, it's not that way. You have to have symptoms to confirm a diagnosis [of Bipolar Disorder]. You have to see the symptoms yourself to confirm the diagnosis or be reported to you by someone other than the patient that he has noted that the patient has had those symptoms. . . .
>
> I didn't see any symptoms other than what he was reporting, and self-report is different from observation.

Dr. A was then asked to provide examples of "confirmed" symptoms of Bipolar Disorder. He responded:

> [H]e wouldn't be sleeping, he would be up, his speech would be pressured, he'd be observed having psychotic behavior, responding to voices. . .

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[4] From Dr. A's interview by VOPA:

> Q: At any time, did you ever see him exhibit behaviors that could have been consistent with Bipolar Affective Disorder?
> A: No. . . .

Despite Dr. A's contention, SH's medical records are, as Drs. Bigelow and Koshes found, replete with independent, confirmed findings (including Dr. A's own testimony) that SH suffered from symptoms of Bipolar Disorder:

- On 25 August 1995, a DPCS professional, in screening SH for hospitalization, found him to have delusions, hallucinations, bizarre behavior, impaired impulse control, sleep disturbance, and pressured speech. The professional found that SH was "Delusional – thinks he is Jesus Christ." As a result, DPCS moved to hospitalize him.

- On 23 April 1996, a DPCS professional stated that SH was observed by his family with "loose associations, pressured speech, increase in religiosity, increased psychomotor agitation." The professional then noted that those "symptoms are also evident in interview." As a result, DPCS moved to hospitalize him.

- On 24 April 1996, a DPCS professional found that SH's "psychosis is still evident."

- On 24 April 1996, a doctor at Southern Virginia Mental Health Institute found that SH "glances upward and to the left frequently as though he is hearing voices. . . At times he inclines his head suggesting that he is hearing something which the undersigned is not. . . From observation, it appears this patient is experiencing auditory hallucinations."

- On 9 July 1997, a DPCS professional found SH to be withdrawn, suicidal and depressed, as well as having impaired impulse control, impaired judgment and sleep disturbance. As a result, DPCS moved to hospitalize him.

- On 27 April 1998, a DPCS professional found SH to be exhibiting "Psychotic-Like Behavior" including "poor personal hygiene, suspiciousness, irritability, poor judgment [and] hallucinations." The professional described SH's thought content as "suicidal" and "hallucinations."

- On 27 April 1998, a DPCS professional observed and described SH as displaying symptoms including paranoia, poor self care, hallucinations, impaired impulse control, bizarre behavior, impaired judgment, sleep disturbance, and pressured speech. As a result, DPCS moved to hospitalize him.

- On 4 October 2000, a DPCS professional found that SH "laughs often during speech" and that his affect was inconsistent with his mood. The

professional noted that SH was experiencing visual hallucinations. Later that day, a DPCS doctor found that SH, besides saying things like "I can see it coming" and "tick, tick, tick boom," was showing symptoms of his disability including "his concentration and attention are poor. . . There is much hesitation between my questions and his responses as if he is having a difficult time understanding what I am asking or how to respond." As a result, DPCS moved to hospitalize him.

- On 12 February 2001, DPCS found SH, at a time when he claimed to have conjured a demon named "Asmodious" and predicted an assassination attempt on the president, to be "hypomanic." The DPCS professional also found SH's speech to be "pressured," his mood to be "anxious…fearful," his thought content to contain "delusions. . .ideas of grandiose. . . paranoid," his thought process to be characterized by "loose associations and flight of ideas." The professional found him to be suffering from "active psychosis" As a result, DPCS moved to hospitalize him.

- On 14 February 2001, Dr. A himself testified at SH's commitment hearing. Dr. A specifically stated that "[f]rom prior contact with [SH], he has exhibited... [and] displayed symptoms consistent with mania in the past as well as hypomania, as well as delusions, bizarre ideation in my contact with him."

  Dr. A then testified that, in his opinion, SH was psychotic.

  When Dr. A was asked how he could find SH was psychotic when the doctor at Southern Virginia Mental Health Institute (Dr. R) had found him not to be psychotic, Dr. A stated, "I've seen him delusional before and that's my opinion that he does have mental illness."

- On 28 July 2001, a DPCS professional found SH to be "hypervigilant." His speech was "pressured," his thought form was a "flight of ideas," his thought content was "hallucinations . . . delusions," and his insight and judgment were noted as "poor."

- On 28 July 2001, SH was seen by a doctor at Danville Regional Medical Center, who found him to be "very psychotic, very delusional, also paranoid and over-anxious and overwhelmed."

- On 30 July 2001, SH was seen by a DPCS professional when he professed a desire to be discharged from Danville Regional Medical Center. The professional found his thought content to be "delusions . . . ideas of grandiose . . . paranoid." He was specifically noted to have hallucinations. The professional stated "Client loose and delusional at times during the conversation." The professional also found him to be in "active psychosis." He was convinced to remain in the hospital.

- On 1 December 2001, after Dr. A had discontinued his antipsychotic medication, SH was seen at Danville Regional Medical Center. The doctor who saw him found "The patient is extremely depressed with psychomotor retardation, preoccupied. . . . Judgment and insight are impaired from psychosis."

Moreover, even if one accepts Dr. A's description of the "confirmed" symptoms of Bipolar Disorder – "[H]e wouldn't be sleeping, he would be up, his speech would be pressured, he'd be observed having psychotic behavior, responding to voices. . ." – SH's records provide the "confirmation" that Dr. A said was lacking. For example, the record is replete with independent findings of pressured speech (noted on 25 August 1995, 23 April 1996, 27 April 1998, 12 February 2001, 28 April 2001, 28 July 2001), sleep disturbances (noted on 25 August 1995, 9 July 1997, 23 April 1998, 18 September 2000, 12 February 2001, 28 July 2001, 30 July 2001), psychotic behavior (noted on 24 April 1996, 9 July 1997, 27 April 1998, 14 February 2001, 28 July 2001), and responding to voices (noted on 24 April 1996).

After reviewing this matter, both of the experts consulted by VOPA took issue with Dr. A's actions. Dr. Bigelow called Dr. A's change of diagnosis "peculiar" and "unexplainable" stating that SH's record "cites and documents numerous psychotic symptoms. . . ." Dr. Koshes found that Dr. A's diagnosis and withdrawal of SH's antipsychotic medications were erroneous, stating:

> There is not sufficient evidence in the medical record, or in the interviews with Dr. A or Dr. R which would warrant a change in diagnosis or treatment withdrawal.

Nevertheless, Dr. A changed SH's diagnosis and withdrew his antipsychotic medications, leading Dr. Koshes to find:

> Predictably, SH decompensated and required hospitalization when his medication was withdrawn. . . . In fact, there was ample evidence in the medical record that non-compliance would cause a recurrence of symptoms.

In sum, DPCS formulated, in Dr. Koshes's words, a "poorly conceived treatment plan," centered on Dr. A's incorrect finding that SH did not have Bipolar Disorder and his improper withdrawal of SH's antipsychotic medications, which resulted in SH's decompensation and hospitalization. Therefore, VOPA finds that DPCS neglected SH by denying him needed treatment and placing him at risk of injury.

3. DPCS Used an Improper Diagnostic Method in Finding that SH Did Not Have Bipolar Disorder

Secondly, VOPA finds that DPCS neglected SH when Dr. A failed to review and consider SH's history of diagnosis and treatment, which led to the erroneous diagnosis that SH did not have Bipolar Disorder, the improper discontinuation of SH's antipsychotic medication and SH's decompensation and hospitalization.

Dr. A changed SH's diagnosis without appropriately reviewing and considering SH's past medical records and history. Thus, it is unsurprising that Dr. A could not "confirm" SH's Bipolar Disorder because he did not appropriately review SH's records or consult with the people who could, and did, confirm it. Proof of this is found in Dr. A's interview:

> Q: Did you do anything to try to confirm through other means at any point..., from other doctors, that he might have Bipolar Affective Disorder?
> A: Other doctors like who?
>
> Q: [Dr. T] who is here, saying he was Bipolar, [Dr. P], who is at Danville, either of the [Dr. Ps], who are either at Danville or the Piedmont CSB who treated him.
> A: I don't think one is able to recall that much unless that person sticks out but I admit –

Q: You didn't try?
A: I didn't try to call them.[5]

In fact, in his interview, Dr. A seemed to state that, **if** SH's symptoms had been confirmed by another doctor, he **would** have found that SH had Bipolar Disorder:

Q: So had you talked to other doctors who confirm those symptoms . . . you then would not have called it Bipolar Affective Disorder, by history, you would have felt it was confirmed?
A: Could you repeat that?

Q: I'm again trying to understand the difference between by history . . . and just Bipolar Affective Disorder. What you said to me . . . was if the symptoms were confirmed . . . it would be. . . Bipolar Affective Disorder because the symptoms had been confirmed, either by you or by someone who had reported it to you other than him.
A: Uh huh.

Q: That's correct?
A: Uh huh.[6]

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[5] From another part of Dr. A's interview:

Q: Did you check with any of his previous physicians to see if they could have reported to you Bipolar Affective Disorder symptoms?
A: No, I have not.
Q: Okay. There was a point on February 26, 2001, where you said Bipolar Affective Disorder, by history, which, as you just said, means he reports it but you can't get it confirmed. Did you take any steps to try to get it confirmed?
A: Not necessarily. It's not a matter of confirmation here.

Dr. A's statement "It's not a matter of confirmation here" conflicts with his earlier comment that "You have to have symptoms to confirm a diagnosis [of Bipolar Disorder]. You have to see the symptoms yourself to confirm the diagnosis or be reported to you by someone other than the patient that he has noted that the patient has had those symptoms. . . ."

[6] But, note Dr. A's response to the next interview question:

Q: Okay, so what would have been required for you to find him to be, on February 26, 2001, Bipolar Affective Disorder and not Bipolar Affective Disorder, by history, would have been for you to have had those symptoms confirmed to you?
A: Not necessarily. I think it was a shortcoming on my part in the beginning to say not qualified Bipolar Affective Disorder. . . . If, if it had been qualified, it would have made a difference here.

It is worth noting that Dr. A never identified any difference between a "qualified" symptom and a "confirmed" symptom and, at any rate, never attempted to contact any professionals or doctors to have the symptoms "qualified" or "confirmed."

Had Dr. A contacted the doctors who had previously found that SH has Bipolar Disorder, had he spoken with any of the DPCS professionals who had independently documented SH's symptoms, had he reviewed SH's medical records or even reviewed his own testimony of 14 February 2001, he would have found the "confirmation" of SH's symptoms that he said was lacking. Thus, Dr. A denied himself the confirmation he demanded. For example, in his interview, Dr. A described the difference between a self-report of hearing voices from a confirmed report:

> Q: How would hearing voices be anything other than self-report? . . . He would tell someone he's hearing voices? I'm confused. . . .
> A: That's exactly how someone [would act]. . . You would try to find out where the voice is coming from.
>
> Attorney for DPCS: Since this is a transcript
>
> Q: You were looking about confusedly.

When Dr. A was "looking about confusedly," he pantomimed a person looking around the room, responding to voices he heard coming from someone he could not see, demonstrating what a professional would have to see and note to confirm that someone was hearing voices. A review of SH's records indicates that a previous doctor had found SH to act exactly in that manner. On 24 April 1996, a doctor at Southern Virginia Mental Health Institute indicated that SH:

> glances upward and to the left frequently as though he is hearing voices. . . At times he inclines his head suggesting that he is hearing something which the undersigned is not. . . From observation, it appears this patient is experiencing auditory hallucinations.

Thus, if Dr. A had appropriately reviewed SH's records, he would have found that SH was independently noted to act **precisely** as he described a person truly hearing voices

"should" act. Such a review would have provided the "confirmation" Dr. A felt he needed in order to find that SH had Bipolar Disorder.

Finally, Dr. A either failed to recall his prior testimony or ignored it. On 14 February 2001, Dr. A testified he had seen SH display symptoms of Bipolar Disorder:

> From prior contact with SH, he has exhibited, and from review [of the] record, displayed symptoms consistent with mania in the past as well as hypomania, as well as delusions, bizarre ideation in my contacts with him.

In fact, while testifying, Dr. A disagreed with Dr. R (whose opinion he later cited as proof that SH did not have Bipolar Disorder) over her finding that he was not psychotic:

> Attorney: Do you think [SH] is psychotic?
> Dr. A: Yes.
>
> Attorney: Would it surprise you that the treating psychiatrist at Southern Virginia [Mental Health Institute] said he is not psychotic?
> Dr. A: Yes.
>
> Attorney: How do you explain the difference between your opinion and Southern Virginia's?
> Dr. A: I've had the pleasure of reviewing prior records at community services [DPCS]. I've seen him delusional before and that's my opinion that he does have mental illness.

Thus, by his own testimony, Dr. A "confirmed" SH's Bipolar Disorder. Additionally, Dr. A did not state, either in his findings or in his interview, that he had come to a different conclusion than he had drawn and testified to in February 2001. Had he done so and provided appropriate reasons for the change in diagnosis, the change may have been understandable. However, based upon his statements that SH's symptoms were never confirmed, when, in fact, **he** had confirmed them, it seems clear that he had not changed his mind about SH's psychotic state in February 2001 but had ignored or disregarded his own testimony.

As Dr. Koshes found, Dr. A's failure to review and appreciate SH's history and records – which, Dr. Bigelow states, "amply establish[] the presence of a psychotic diagnosis" – led to DPCS formulating a "poorly conceived treatment plan" resulting in the withdrawal of SH's antipsychotic medications. Dr. Koshes opined that Dr. A knew or should have known that SH would decompensate and need to be hospitalized if his antipsychotic medications were withdrawn. Hence, VOPA finds that DPCS neglected SH, as a result of Dr. A's failure to appropriately review and consider SH's history, by denying SH needed treatment and placing him at risk of injury.

4. DPCS Improperly Discontinued SH's Antipsychotic Medication

Third, VOPA finds that DPCS neglected SH when it abruptly discontinued his antipsychotic medication, resulting in his decompensation and hospitalization. As Dr. Koshes stated:

> Fail[ing] to appreciate the significance of SH's past history, [Dr. A] discontinued the antipsychotic medication without either tapering the medication or providing SH with guidance on what to do should symptoms re-occur. This resulted in the hospitalization of SH for symptoms of his mental illness. This indicated a failure to provide an adequate level of care, and violated accepted standards of psychiatric care.

Dr. Koshes further found that DPCS knew or should have known that the withdrawal of SH's antipsychotic medication would lead to his decompensation and hospitalization, stating:

> Predictably, SH decompensated and required hospitalization [when his antipsychotic medication was withdrawn]. . . . In fact, there was ample evidence in the medical record that non-compliance would cause a recurrence of symptoms.

SH's records clearly support Dr. Koshes' opinion, documenting numerous occasions when SH decompensated and required hospitalization when he did not take his antipsychotic medication:

- On 9 July 1997, following three weeks without taking his antipsychotic medication, SH was hospitalized with symptoms including impaired judgment, sleep disturbance, depression and suicidal ideation.

- On 27 April 1998, following two months without taking his antipsychotic medication, SH was hospitalized with symptoms including paranoia, hallucinations, impaired judgment, sleep disturbance, and pressured speech.

- On 4 October 2000, following twp weeks without taking his antipsychotic medication, SH was hospitalized with symptoms including visual hallucinations, affect inconsistent with mood, poor insight and poor judgment.

- On 12 February 2001, following "sporadic" medication noncompliance, SH was hospitalized with symptoms including delusions, pressured speech, hypomania, sleep disturbance, and paranoia.

- On 14 February 2001, Dr. A testified that if SH did not take his antipsychotic medications, he would likely become manic, be unable to care for himself, and would need to be hospitalized.

- On 28 July 2001, following two weeks without taking his antipsychotic medication, SH was hospitalized with symptoms including delusions. Two days later, DPCS noted that symptoms including delusions, paranoia, hallucinations and sleep disturbance were still present.

Thus, there is substantial evidence to support Dr. Koshes' opinion that it was "predictable" that SH would decompensate and need to be hospitalized if his antipsychotic medication was withdrawn. Moreover, DPCS was well aware of this fact because DPCS professionals (including Dr. A) noted the relationship between SH's failure to take his antipsychotic medication and his decompensation.

Given DPCS's knowledge that SH would likely decompensate if he did not take antipsychotic medications, it is particularly distressing that DPCS did not attempt to set up a

treatment plan to monitor SH for signs of decompensation. Because SH's history suggested that decompensation was likely, DPCS should have counseled SH on what to do if he felt his symptoms returning and set up an accelerated appointment schedule (Dr. Koshes suggested a two-to-four week interval between appointments) to monitor him for signs of decompensation.

Unfortunately, these steps were not taken. The result was precisely as predicted by Dr. A in February 2001: when SH did not, because he could not, take his antipsychotic medication, he decompensated and was hospitalized.

Finally, it is noteworthy that, after SH decompensated in December 2001, he was re-prescribed antipsychotic medication by Danville Regional Memorial Hospital. After his release from the hospital, DPSC re-filled SH's antipsychotic medication prescription. While Dr. R, the DPCS doctor who re-filled the prescription, denied that she did so because she had come to the conclusion that SH needed the antipsychotic medication, her actions were, if not taken for that reason, curious.[7]

In sum, DPCS improperly withdrew SH's antipsychotic medication and did not take any steps to either gradually taper him off the medication or closely monitor him for signs of decompensation. As a result, SH decompensated and was hospitalized. Therefore, VOPA finds that DPCS neglected SH by denying him needed treatment and putting him at risk of injury.

5. DPCS Did Not Have an Appropriate Structure in Place to Supervise its Doctors

Finally, VOPA finds that DPCS neglected SH when it failed to create and implement an appropriate supervisory structure. Had DPCS adequately supervised Dr. A, it is

[7] To her credit, Dr. R. recommended, in October of 2001, that SH be gradually tapered from his antipsychotic medication, as opposed to Dr. A, who abruptly discontinued it.

likely that SH's diagnosis would not have been erroneously changed or his antipsychotic medication improperly withdrawn.

At the time DPCS neglected SH, its Director of Mental Health Services, Dr. A's supervisor, was not (and is not now) a doctor. In her interview, she admitted that she did not get involved with individual client treatment decisions and that no one at DPCS has the authority to override a doctor's diagnosis or treatment decisions:

> Q: You don't give treatment directions?
> A: Not like around treatment planning and direct service, you know, or the other things like that. . . .
>
> Q: Who was the supervisor in [SH's] case?. . .
> A: Again, [SH] was seeing the psychiatrist, who I directly supervise. . . .
>
> Q: But you directly supervise the psychiatrist, and I'm trying to figure out. . . is whether there was a time when you or anybody else got directly involved in treatment decisions being made by the psychiatrist or whether there was oversight over the treatment provided by the psychiatrist. . . .
> A: Okay. What I remember is that last year there was a time when [SH] and [Dr. A], who was the treating physician at the time, had a particularly difficult session. . . when [SH] left the building that day, went down the hall and talked to. . . [the] Director of Clinical Services, to let him know that he thought [SH] might come up on crisis. . . . So at that point, I was contacted by [the Director of Clinical Services] around, you know, when things rise to that kind of level then I'm usually notified, contacted, involved in some way around, you know, well what's happening and, you know, exactly what is the problem, then what's our next step, who do we want to include in the treatment team, that sort of thing. So in that matter I would certainly had some oversight. I wouldn't say that the responsibility for the direction of the clinical course of treatment . . . but certainly involved. . . .
>
> Q: You kind of had what I would call administrative oversight. . . .
> A: Uh huh. . . .
>
> Q: You organized it, but with regard to clinical oversight, is there any of that? . . .
> A: Would I advise. . . .what the clinical course of treatment is . . . certainly, if he wanted to have some dialogue . . . around clinical

course of treatment and, and what we think is the best option for that consumer. Would I override a physician's diagnosis? Would I override any other clinician's diagnosis just to step in? No, I don't see myself in that role or that capacity. I, I, you know, I don't see consumers here in that kind of clinical capacity. . . .

Q: Do you have anyone here who . . . is a clinical supervisor who might have that authority?
A: The authority to override a physician? . . . .

Q: Is there a person here who has the authority to . . . look [at] diagnosis and treatment . . . and either confer or override? . . .
A: Meet and confer, certainly; the authority to override a physician's diagnosis, no.

In reviewing this case, Dr. Koshes found that DPCS had:

no process for medical supervision of the psychiatrists [it] employed. . . . A non-psychiatrist, non-medical doctor, cannot medically supervise a psychiatrist. Medical supervision requires the monitoring of quality care and regular evaluation of standard of care practices.

In short, there was no person at DPCS who could review Dr. A's work and intervene on behalf of SH. Dr. Koshes found that, had such a person existed, SH's case "would likely have had a different outcome."

However, unfortunately for SH, Dr. A's supervisor was a non-psychiatrist, someone who pointedly would **not** involve herself in or disagree with Dr. A's diagnostic or treatment decisions, even when she knew (as she did in this matter) that Dr. A's diagnosis had been questioned. As a result, Dr. A worked with little or no oversight – his diagnoses and treatment decisions would not, indeed could not, be questioned. Thus, DPCS had no way to ensure that Dr. A provided appropriate care to his patients, and when inappropriate care was rendered, as it was in this case, there was no way for DPCS to recognize and correct it.

One specific incident illustrates DPCS's failure to oversee and ensure the quality of the care received by SH. On 12 February 2001, SH was examined by Dr. R at Southern

Virginia Mental Health Institute. She found that he did not have Bipolar Disorder. On 26 February 2001, Dr. A saw SH and reported that he:

> was recently discharged from Southern Virginia Mental Health Institute. Discharge summary indicates that client has no Axis I diagnosis and Axis II is Personality Disorder, NOS. I discussed with [Dr. R] from Southern Virginia who indicates that she believes the medication is to help with his personality problems.

Based, it seems, on Dr. R's report, Dr. A changed SH's diagnosis from "Bipolar Affective Disorder" to "Bipolar Affective Disorder, by history."[8] On 18 October 2001, Dr. A informed SH that he did not believe that SH had Bipolar Disorder and withdrew his antipsychotic medication. SH then requested a second opinion. DPCS assigned Dr. R to examine SH and provide the second opinion; thereby assigning the doctor who originally opined that SH did not have Bipolar Disorder, and on whose report Dr. A relied in changing his diagnosis, to give an "independent" second opinion. Not surprisingly, Dr. R's "second opinion" was consistent with her first opinion: she found that SH did not have Bipolar Disorder.

Both Dr. Koshes and Dr. Bigelow took issue with DPCS's assignment of Dr. R to provide an "independent" opinion. Dr. Bigelow stated that Dr. R "can scarcely be considered to be an independent outside person." Dr. Koshes also criticized DPCS, stating:

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[8] In his interview, Dr. A stated that Dr. R's finding that SH did not have Bipolar Disorder "put a question mark beside the diagnosis" that SH did have Bipolar Disorder.

Oddly, on the same day that he changed SH's diagnosis, Dr. A issued a report indicating that, in his opinion, SH had Bipolar Disorder. In his report, Dr. A stated that he agreed with SH's treatment plan, which stated that SH had Bipolar Disorder. When questioned about this seeming contradiction – how on the same day, the same doctor could both state affirmatively that SH had and did not have Bipolar Disorder – DPCS's Director of Mental Health Services stated that Dr. A's report that SH had Bipolar Disorder was "a Medicaid requirement for [SH] to be authorized to receive outpatient counseling services." Any question of whether this action was or may have been unlawful, given that Dr. A and DPCS seem to have given a diagnosis to Medicaid that they did not agree with (and continued to do so: DPCS, even after SH's diagnosis was changed, stated, on their billing statements to Medicaid, that SH was diagnosed with Bipolar Disorder), in order to receive payment from Medicaid, is beyond the scope of this investigation.

> [W]hen a second opinion was agreed upon by the treatment team, the facility should have scheduled this evaluation with a provider who had not seen the patient previously. This would have been ideally conducted with a psychiatrist outside of the institution seeking the second opinion.

The reason for the experts' findings is obvious: a second opinion should be truly independent and not based on or complicated by any pre-existing biases. However, when Dr. Koshes questioned DPCS about its assignment of Dr. R, DPCS's Director of Mental Health Services stated that DPCS used Dr. R because she was the only physician employed by "our Agency that SH had not previously seen at DPCS." In other words, DPCS **intentionally** chose Dr. R to do the second opinion **because of** her affiliation with the facility.

The use of Dr. R, who rendered what was, effectively, the "first opinion," to provide an "independent" second opinion raises serious questions and concerns up to and including whether DPCS was ever truly committed to giving SH an independent second opinion or, instead, arranged matters to ensure that the second opinion would mirror the first. While VOPA cannot and does not seek to determine DPCS's motivation, DPCS's actions, whether intentional or not, effectively guaranteed that Dr. A's opinion would be confirmed.

The use of Dr. R to provide an "independent" second opinion is particularly grievous given that DPCS's Director of Mental Health Services stated that she would never disagree with a doctor's diagnosis or treatment decisions. Within this supervisory vacuum, DPCS arranged for an "independent" second opinion by a doctor who would, like the Director, almost certainly refuse to second-guess Dr. A's decisions. Clearly, this was a failure to provide adequate and appropriate medical supervision, which, in Dr. Koshes words, "requires monitoring of quality care and regular evaluation of standard of care practices." This episode underscores Dr. Koshes's finding that DPCS had no mechanism to ensure that it provided quality medical care because any kind of effective supervisory structure would have recognized and avoided the

inherent conflict of interest in using Dr. R to provide a second opinion. DPCS's lack of oversight into such an elementary matter speaks ill of its ability to oversee the quality of complex issues such as the diagnosis and treatment of its patients.

In sum, as Dr. Koshes found, SH probably would not have decompensated and been hospitalized if DPCS had an effective supervisory structure in place. Therefore, VOPA finds that DPCS neglected SH by failing to adequately supervise its doctors, leading to a failure to provide needed treatment to SH and putting him at risk of injury.

VI. RECOMMENDATIONS

It is difficult to make recommendations in a matter such as this because there are no steps that DPCS can take that would make SH "whole." Nothing DPCS does in response to this report can correct Dr. A's incorrect diagnosis and incorrect diagnostic procedure, result in DPCS adequately supervising Dr. A's work on SH's case or, most importantly, erase his decompensation and hospitalization. Therefore, these recommendations are designed to ensure that DPCS will not commit future acts of neglect.

A. DPCS must create and implement a system that appropriately supervises its doctors. The system must be headed by a medical professional who has the power to oversee and correct diagnostic and treatment decisions.

B. DPCS must create and implement an effective "peer review" system through which doctors and supervisory staff can review, question and correct each diagnostic and treatment decisions.

C. DPCS must ensure that, when a patient requests a second opinion, a truly independent opinion is provided.

D. DPCS must create and implement a system to discipline its doctors who make incorrect diagnoses and employ improper diagnostic procedures.

VII. VOPA'S REPLY TO DPCS'S RESPONSE

DPCS's response to VOPA's report is attached hereto as Exhibit C. This section is included in order to reply to points raised in DPCS's response.

A. VOPA's Reply to DPCS's Complaint that it Cannot Respond to the Conclusions Reached in the Report

Rather than respond to the factual and legal conclusions made by VOPA, DPCS spends a vast amount of time and energy in an attempt to impugn the integrity and motivations of VOPA and the staff person who conducted this investigation. These attacks vary from the inconsistent (complaining, alternately, that the investigator asked "lawyer-like" yes-or-no questions and that he "demonstrat[ed] either an inability or unwillingness to ask questions that were short, to the point, or easy to understand") to the irrelevant (complaining about the investigator's posture) to the impossible (complaining that VOPA should have released certain confidential documents and information to it when VOPA was forbidden by state and federal law to do so) to the false and, seemingly, defamatory.

In the midst, or, perhaps, because of these attacks, DPCS never presents evidence to refute VOPA's factual or legal conclusions. DPCS never denies that its diagnosis was incorrect, never contends that its diagnostic procedure was proper, and never argues that its withdrawal of SH's medication was not neglectful. DPCS's only affirmative statements about its care – that it provided SH with an independent assessment and adequately supervises its doctors – are, respectively, contradicted by the record and offered as a conclusory statement without evidentiary support.

Instead of refuting VOPA's findings, DPCS argues that it is unable to respond to VOPA's conclusions. DPCS's contention is absurd.[9] DPCS had and continues to have at its disposal all of the information relied upon by VOPA and the experts it consulted. In reaching its conclusions, VOPA and the experts reviewed SH's records, which were either possessed by or available to DPCS[10], and the transcripts of interviews with DPCS employees, which DPCS has in its possession.[11] Thus, there is simply no reason why DPCS could not have done exactly what VOPA did: provide the records of this case to an expert[12] or, even its own medical staff, for the purpose of seeking an opinion as to whether it neglected SH. It is disingenuous for DPCS, which wasted thousands of dollars in a failed attempt to quash this report, to argue that it lacks the resources to seek such an opinion.

Moreover, DPCS's arguments that it was prejudiced by the time it took to produce the report are meritless because DPCS, itself, was responsible for much of the delay, and, more importantly, because SH's records and the transcripts have not changed with the passing of time. At any time up to and including the present, DPCS can provide the records to an expert and ask for an opinion. The fact that DPCS has refused to do so – choosing instead to engage in character assassination – speaks volumes about the confidence it has in its treatment of SH.

B. VOPA's Reply to DPCS's Complaint that VOPA Did Not Cite to the Report of its Second Expert

In its draft report, VOPA extensively cited to and quoted Dr. Koshes's opinion.

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[9] VOPA takes DPCS's dismissing of its own lawsuit as an admission that VOPA did not violate DPCS's legal rights.

[10] For example. Dr. A's February 2001 testimony is a matter of public record.

[11] Dr. Koshes reviewed both the records and transcripts. Dr. Bigelow reviewed records, only.

[12] DPCS would, of course, have to seek SH's permission to do so.

VOPA also indicated that it had consulted with another expert in the course of this investigation. DPCS criticizes VOPA for not citing to or quoting the report of the "anonymous expert."

VOPA agrees with DPCS that it should have included citations to the report of its second expert, Dr. Llewellyn B. Bigelow, a Harvard educated, Board Certified psychiatrist who is a Life Fellow in the American Psychiatric Association. So that no negative inference can or will be drawn from VOPA's prior decision not to cite to Dr. Bigelow's report, VOPA has chosen to include his findings – including his opinion that "the deliberate withdrawal of treatment from [SH] and the unexplainable change in diagnosis, probably, in my opinion, must expose both [Drs A and R] and [DPCS] to a significant malpractice suit for their actions" – with this final report.

C. VOPA's Reply to DPCS's Contention that Dr. R Provided an Independent Evaluation

DPCS's argument that Dr. R provided an appropriate, independent evaluation is contradicted by its own response and Dr. R's report. DPCS bases its conclusion on its contention that SH did not see Dr. R for a "second opinion" but, instead, because he wanted to see a doctor other than Dr. A. However, the fact remains (as admitted by DCPS in its response) that DPCS informed SH that he would be seeing Dr. R for a second opinion. Moreover, Dr. R's report of 23 October 2001 makes it clear that she was seeing SH for the purposes of providing him with a second opinion "at the request of both the client and the clinic's administration."

Thus, regardless of DPCS's contention concerning what SH may have thought, DPCS scheduled the appointment as a second opinion and Dr. R understood the appointment to be for that purpose. Given DPCS's intent and Dr. R's understanding, DPCS had an obligation to conduct an appropriate, independent second opinion. Despite DPCS's contention that SH received such an assessment, the facts of this case and the opinions of Drs. Koshes and Bigelow prove otherwise.

D. VOPA's Reply to DPCS's Statement that it Adequately Supervises its Doctors

The facts of this case and the opinions of the experts contradict DPCS's conclusory statement that it adequately supervises its doctors. DPCS has provided no evidence that it has changed the supervisory structure that Dr. Koshes found to contribute to SH's decompensation and hospitalization. In other words, DPCS's doctors are still supervised by a non-doctor who cannot or will not supervise them.

DPCS's conclusory statement that it adequately supervises its doctors is contradicted by the evidence and expert opinion in this case as well as by the words of DPCS's Director of Mental Health Services:

> Q: Do you have anyone here who . . . is a clinical supervisor who might have that authority?
> A: The authority to override a physician? . . . .
>
> Q: Is there a person here who has the authority to . . . look [at] diagnosis and treatment . . . and either confer or override? . . .
> A: Meet and confer, certainly; the authority to override a physician's diagnosis, no.

DPCS's failure to adequately supervise its doctors – to have someone over them with the will and ability to review and override their diagnoses and treatment decisions – effectively dooms its patients to neglect whenever a DPCS doctor makes an incorrect diagnosis or treatment decision.

VIII. CONCLUSION

This report did not come about simply because VOPA disagrees with DPCS's diagnosis and treatment of SH. To quote Dr. Koshes, the intent of this report:

> is not to say that a psychiatrist cannot question previous diagnoses. In fact, this is a useful position to take at times. Determining the presence of a psychiatric illness in a patient who is taking medications is complicated, but can be accomplished.

VOPA acknowledges that professionals can and do disagree (without either being "wrong") on matters as complicated and nuanced as a specific diagnosis of mental illness and a particular plan for treatment. However, rather than being an issue of simple disagreement with a defensible diagnosis, this matter came about because DPCS embarked upon a method of diagnosis and treatment that, seemingly, ignored or disregarded important steps necessary to arrive at a proper diagnosis and treatment plan. In his report, Dr. Koshes sets forth the critical steps that DPCS should have taken in SH's case and should take in similar cases in the future:

> First, the previous medical records must be consulted to determine the symptoms in question. Secondly, the treatment team and patients should be in agreement with a plan to withdraw medication and monitor symptoms. Target symptoms are identified and medication is gradually weaned. Close follow-up is provided. Two to four weeks between visits is sufficient with concurrent psychotherapeutic support. Medication should not be stopped abruptly, as was effectively done in this case.

Rather than follow these steps, DPCS failed or refused to consider SH's past medical records and history. This failure led to its incorrect diagnosis that SH did not have Bipolar Disorder and its improper withdrawal of SH's antipsychotic medication. In Dr. Koshes' words, "This approach to diagnosis and treatment most likely led to [SH's] subsequent decompensation and hospitalization."

Dated: 12 September 2003

Respectfully Submitted
Virginia Office for Protection and Advocacy
202 N. 9th Street, 9th Floor
Richmond, VA 23219
(804) 225-2042

By: _____
Jonathan G. Martinis
Managing Attorney, PAIMI Program[13]

[13] John W. Phelps, former Disability Rights Advocate for VOPA, was instrumental in the conducting of this investigation.

EXHIBIT A

LLEWELLYN B. BIGELOW, M.D.
423 SOUTH LEE STREET
ALEXANDRIA, VIRGINIA 22314
703-548-7751

June 18, 2002

Mr. Jonathon Martinis, Managing Attorney
Department for Rights of Virginians with Disabilities
202 North 9th St., 9th Floor
Richmond, VA 23219

RE: Mr. [redacted] H[redacted]

Dear Jonathon,

This letter is in response to your request that I evaluate the records of Mr. H[redacted] to see if the changes in diagnosis that occurred last fall are justified. To make a long story short, the change in diagnosis is so inappropriate as to make one wonder how and why any professional might change his diagnosis and, apparently, justify removing a critical component of his treatment, the antipsychotic drug risperdal. The earlier data from Central State Hospital amply establishes the presence of a psychotic diagnosis. At that time some entities concluded bipolar disorder and others paranoid schizophrenia – a distinction that at times is difficult to make. There is no question that the correct diagnosis is of a psychotic disorder. Dr. R[redacted] placed in her note of October 23, 2001, a comment that can only be described as bizarre: "The client did not describe any symptoms that would describe discrete episodes of mania or depression." The Central State Hospital cites and documents numerous psychotic symptoms consistent with both mania and schizophrenia.

During intervening years Mr. H[redacted] demonstrated the correctness of this diagnosis by decompensating and becoming psychotic whenever he failed to take antipsychotic drugs. Refusing to take chronic medications is common in mental disorders. It takes time to be convinced.

In any case, apparently Mr. H[redacted] had become convinced after many years when he pled with his "caregivers" to continue his antipsychotic medication after it had been discontinued. For some undocumented reason a Dr. A[redacted] decided to change his diagnosis to an Axis II and throw in Alcohol Abuse despite the lack of any evidence in recent years that alcohol had played any significant role in his life!

Mr. H[redacted] objections to his new diagnosis, which carried an implication of inappropriate treatment was remarkably appropriate. Like many who have a chronic illness such as schizophrenia or bipolar disorder, he has come gradually to accept the facts of his handicap and try to work as best as he can to forge a new life.

I reviewed with some care a consultative note by a Dr. [redacted] dated October 23, 2001 – well after the peculiar change in diagnosis by Dr. A[redacted]. My understanding is that Dr. R[redacted] works at the same facility as Dr.A[redacted] and thus can scarcely be considered to be an independent outside person. It contains so many inaccurate distortions of current diagnostic terminology and of Mr. H[redacted]s history that I will not enumerate them here. Should the occasion arise that this could be helpful I would be glad to provide a detailed listing.

Because there seems to be a diagnosis of alcohol abuse it might be informative to search for some data to support this conclusion. I could find nothing except Mr. H[redacted] statement the he and others drank to much during their experience as military recruits – not very remarkable. The only evidence that this might have been a significant factor comes from his early rather guilty remark that he thought that it might have impaired his performance.

After this there is very limited reference to alcohol intake, but as often happens, the diagnosis of alcohol was simply carried forward through the record of the client long after it has any relevance. One can merely note that at every emergency room intake saw the entry "no alcohol" involved was checked.

Finally I would note that the deliberate withdrawal of treatment from Mr. H[redacted] and the unexplainable change in diagnosis probably, in my opinion, must expose both Drs A[redacted] and R[redacted] and their local Community Service Board to a significant malpractice suit for their actions. I am glad to hear that you were able to arrange appropriate treatment for Mr. H[redacted] at another facility and hope that he did not suffer any permanent damage from his earlier inadequate treatment.

Please let me know if I can provide further information. If required, I would be glad to back up the opinions expressed here with further detail.

Sincerely,

Llewellyn B. Bigelow, M.D.
Board Certified
Life Fellow, American Psychiatric Association

EXHIBIT B

RONALD J. KOSHES, M.D.
Diplomate of the American Board of Psychiatry and Neurology

1348 East Capitol Street, N.E.
Washington, D.C. 20003
(202) 543-0406

REVIEW OF CLINICAL RECORDS AND CARE

For
The Commonwealth of Virginia
Virginia Office for Protection and Advocacy

RE: [redacted]
D.O.B: July 9, 1966

IDENTIFYING INFORMATION: The subject is a 36-year-old, Caucasian male residing in Virginia and receiving outpatient psychiatric treatment at Piedmont Community Services Board. On September 27, 2002 the undersigned was engaged by the Virginia Office for Protection and Advocacy to review the clinical management of [redacted] since his enrollment in mental health services at Danville-Pittsylvania Community Services Board. The medical records and other pertinent information were referred to the undersigned on or about September 30, 2002, by Jonathan G. Martinis, Esq., Managing Attorney, of the Commonwealth of Virginia, Virginia Office for Protection and Advocacy, for assistance in the investigation of whether [redacted] treatment at the Danville-Pittsylvania Community Services Board met accepted standards of psychiatric care.

A professional services agreement dated September 27, 2002 by Ms. Heidi Lawyer,

Acting Director, Virginia Office for Protection and Advocacy, delineated the scope of services to be performed by an expert reviewer. Clinical records, other correspondence, and other sources of, or access to information (delineated below) were provided by the Virginia Office for Protection and Advocacy for review. Additional information was provided by [redacted], Director of Mental Health Services at the Danville-Pittsylvania Community Services Board, in a letter dated December 23, 2002 (VOPA may not have a copy of this letter, and it is therefore attached to this report.).

DISCLOSURE: Before engaging in a review of the clinical records, it was made clear to the representatives of the Virginia Office for Protection and Advocacy, that a review of the records and other information would be undertaken in a non-biased and scientific manner. Documentation, from various sources, of the clinical management of [redacted] would be the critical material from which an independent judgement of clinical appropriateness and standard of care of the treatment would be made. Additional information would be obtained from the Virginia Office for Protection and Advocacy, [redacted] treating psychiatrists, [redacted] and other clinical staff and parties in this case, as needed. The Virginia Office for Protection and Advocacy was not to assume that the reviewer had any bias in his task and that rendering a sound scientific opinion in the aforementioned case was the principle goal. The Virginia Office for Protection and Advocacy was to understand that an earnest attempt would be undertaken to determine the relevant patient care issues in the [redacted] case. Attention would be paid by the reviewer to the commonly accepted standards of psychiatric care as emulated in peer-reviewed professional publications. Where important, references would be provided.

Having understood the stipulations of the review, the Virginia Office for Protection and Advocacy, through its agents, agreed to commence the clinical review.

SUMMARY OF FINDINGS: Based on a review of the available clinical records, interviews, and

other information provided by the Virginia Office for Protection and Advocacy, the evidence in this investigation indicated that [redacted] care was not appropriate while he was a patient cared for by Dr. [redacted] at the Danville-Pittsylvania Community Services Board. To wit:

1 The clinical record indicated a clear history of Bipolar/Schizoaffective Disorder with multiple hospitalizations for symptoms of these illnesses, and clear documentation by several psychiatrists that [redacted]'s symptoms were not fabricated, nor the result of a Personality Disorder. Dr. [redacted] stated that he did not review the previous clinical records of [redacted], nor did he think it was necessary, resulting in a faulty formulation of the case and a poorly conceived treatment plan. This violated accepted standards of psychiatric care.

2. Failure to appreciate the significance of Mr. [redacted] past history, Dr. [redacted] discontinued the antipsychotic medication without either tapering the medication or providing [redacted] with guidance on what to do should symptoms re-occur. This resulted in the hospitalization of [redacted] for symptoms of his mental illness. This indicated a failure to provide an adequate level of care, and violated accepted standards of psychiatric care.

The conclusion reached in this review Dr. [redacted] failed to recognize the importance of past history, and utilize this data in the treatment of [redacted] resulting in his decompensation and hospitalization. Additional conclusions are contained at the end of this report.

HISTORY OF THE ILLNESS AND INCIDENT: The records available for review and sources of information for the S[redacted] H[redacted] review of care case were as follows:

Medical records from the Danville Community Services Board, including hospital

discharge summaries;

Additional medical records from other facilities;

Telephonic Interviews with [redacted] Clinical Director of NAMI-Virginia, [redacted] Attorney for NAMI-Virginia, and [redacted]

Tape of proceedings of Commitment Hearing of [redacted] on February 14, 2001;

Answers to questions provided to [redacted] Director of Mental Health Services, Danville-Pittsylvania Community Services Board; and

Transcripts of interviews with [redacted] ounselor, Dr. [redacted], his most recent treating psychiatrist at Danville-Pittsylvania Community Services Board; Dr. [redacted], a psychiatrist at Danville-Pittsylvania Community Services Board who treated and interviewed [redacted] H[redacted]ey, Executive Director of the Danville-Pittsylvania Community Services Board, [redacted], Mental Health Services Director of the Danville-Pittsylvania Community Services Board, [redacted], Quality Control employee at the Danville-Pittsylvania Community Services Board, [redacted] Case Manager for [redacted] at the Danville-Pittsylvania Community Services Board, and [redacted] Lead Case Manager at the Danville-Pittsylvania Community Services Board.

PERTINENT HISTORY

The earliest clinical record for review comes from the Danville Pittsylvania Mental Health Services Board dated October 26, 1995. The record described a 29 year old white male who had been previously hospitalized for one month with a diagnosis of Psychosis, Not Otherwise

Specified. He presented to the Danville clinic for outpatient follow-up. When hospitalized, he was described as "paranoid with some ritualistic behavior. . . an extreme level of energy and elation as well as occupations over religious matters." [redacted] reported presently that, in looking back at this initial episode, he clearly was experiencing the symptoms of his illness, and was confused, angry, and in need of the treatment he received.

When seen in the clinic for follow-up he was medicated with haloperidol and was complaining of fatigue and psychomotor retardation. At that time, he admitted to a history of using marijuana which "allows him to experience the spirits beyond what the normal census (sic, most likely 'senses') would allow." He reported a history of counseling in 1991 following a felony conviction of credit card fraud.

The treating psychiatrist at that time in the Danville clinic was Dr. [redacted]. Dr. [redacted] believed that [redacted] was either suffering from Bipolar Disorder, Manic, or Schizoaffective Disorder, Bipolar Type. [redacted] attempted to medicate the patient with lithium, a treatment for these two mentioned diagnoses, but the patient was resistant. He was attended by the same psychiatrist until September 11, 1998, and came to the medication clinic a total of fifteen times. The medication clinic visits documented in the medical record related many periods of non-compliance with medications resulting in increasing symptomatology of depression, paranoia, anxiety, mania, abuse of alcohol, manic behavior, and grandiosity. During this time, [redacted] stated that he did not think he had a mental illness that was serious.

When Mr. H[redacted]s care was assumed by Dr. [redacted] in September 1998, he was taking valproic Acid 750 mg a day, and Zyprexa 5mg in the evening. These medications are mood stabilizing agents and the Zyprexa has additional antipsychotic activity. Dr. [redacted] saw this patient once, and care was resumed with Dr. [redacted]. Continued non-compliance with medication is noted as well as alcohol use sporadically. Dr. [redacted] documented the diagnosis as Bipolar Disorder and added substance abuse to the relevant clinical issues. The prescribed medications were changed during this time period; adjustments were made due to side-effects.

[redacted] saw Dr. [redacted] on October 4, 2000 for the last and tenth time. During this visit, the medications were reviewed and Seroquel, an antipsychotic agent was discontinued. Zyprexa was again restarted. [redacted] was to continue taking the Depakote. Documented during this visit were symptoms of auditory hallucinations, depressed mood and agitation. Dr. [redacted] noted the diagnosis of Bipolar Disorder and assessed that his symptoms resulted from medication non-compliance and the re-emergence of Bipolar Disorder symptoms.

It was during this time period (treatment with Dr. [redacted]) that [redacted] reported he began to accept the fact that he had a mental illness. He felt he had either Schizoaffective Disorder, or Bipolar Disorder. His difficulties, [redacted] reported, stemmed from his inability to control his paranoid thoughts, command hallucinations, anger, and unstable mood. He said he had established contact with NAMI and began paying more attention to his emotional state on a day-to-day basis. [redacted] said that the realization that he had a mental illness was difficult, but this realization allowed him to explain many of his past behaviors which had caused him lose jobs, become irritable, become hospitalized, think "strange" thoughts. He also said that he began trusting the mental health field to take care of his problems. (At the present time, [redacted] demonstrated in the telephonic interview an understanding of the diagnosis of Schizoaffective Disorder, Bipolar Disorder, the symptoms and treatments associated with these conditions, and the importance of treatment compliance in his overall care.)

On October 17, 2000, [redacted] was seen for the first time by Dr. [redacted], who diagnosed him as having Bipolar Affective Disorder, and a history of substance abuse. Dr. [redacted] documented the psychiatric decompensation which occurred two weeks earlier, when [redacted] had stopped taking his medications: "he did experience auditory hallucinations several weeks ago. . . .He did inform me that two or three weeks ago he had this bad feeling regarding what was happening in the Middle East. He stated that he had seen crows and that he felt this was an ominous sign. He went further into his delusions indicating that he believes he is a descendant of the Middle East and the Middle East blood runs in him. This he takes from the scripture, believing that all people in the world are related to each other and are descendants from

the Middle East. He indicates that he is a spiritual person but things have been getting out of hand recently."

[redacted] stated in the telephonic interview conducted on November 5, 2002, that he and Dr. [redacted] "conflicted with each other from day one." [redacted] explained his understanding of this conflict in the following way: "I had read up on my illness, in NAMI literature, the Bipolar Network, and was setting up charts on monitoring my mood. I was reading about conferences about Bipolar Disorder, and became grandiose, starting to read about consciousness, and religious studies of expanding the mind. . . . I am six foot five inches, 270 lbs., and very scary when I raise my voice. People were afraid of me. I don't think he (Dr. [redacted] wanted to listen to me."

Six weeks later, [redacted] attended Dr. [redacted] medication clinic and was noted to be functioning well: "He states that he was at a job interview earlier today. He states that he is sleeping better at night and feels that he is more focused. His appetite continues to be good; his delusions are not as extreme as the last time he was here. He seems to have slowed down somewhat. His speech is goal oriented with no evidence of pressured speech. He denies any auditory, visual or tactile hallucinations at the present time as well as denying any suicidal or homicidal ideation and contracts for safety. No adverse side effects are noted on the medication." Dr. [redacted] diagnosed [redacted] as having Bipolar Affective Disorder, and a history of substance abuse. He noted that [redacted] was taking his medications.

It is important to note that throughout [redacted] treatment at the Danville clinic, there is strong documentation of good functioning when taking prescribed medication, and poor functioning, including hospitalization, when not taking medications as prescribed or not at all.

In February 2001, [redacted] was hospitalized on a Temporary Detention Order, at Southern Virginia Mental Health Institute. He was in the hospital for four days and a history of non-compliance, psychosis, grandiosity, depression, agitation, ideas of reference, neurovegatative

dysfunction, and delusional, paranoid thoughts. These symptoms are described in depth in the initial evaluation of [redacted] at SMVI by Dr. [redacted] In this initial evaluation, the past psychiatric history is described in detail and includes references to medication history, medication non-compliance, diagnoses, and substance use. The mental status examination notes paranoia, delusions of grandeur, and delusions. He was deemed to be a danger to himself.

In testimony during Mr. H[redacted]'s Continued Confinement Hearing, Dr. [redacted] stated that [redacted] was psychotic, suffered from mania, and delusions. Dr. [redacted] stated that "due to the nature of the illness, without adequate treatment, ([redacted]) would suffer from exhaustion, potential collapse" and that [redacted] was "of great concern to me if not hospitalized." Dr. [redacted] characterized the adequate treatment as a combination of mood stabilizer and antipsychotic. Without medications, Dr. [redacted] asserted, [redacted] would not be able to care for himself. Dr. [redacted] stated that he based his claims on a review of the records, and his clinical interview. Dr [redacted] ultimately recommended continued involuntary confinement.

The diagnosis at discharge from SMVI was deferred, and Dr. [redacted] prescribed Depakote 2000 mg, and Zyprexa 20 mg per day. Dr. [redacted] made the diagnosis of a Personality Disorder, Not Otherwise Specified, and considered stopping all medications, and "running some psychological testing."

Dr. [redacted] indicated in the discharge summary, that [redacted] was manipulative, and did not demonstrate a psychotic thought process. She stated that she reviewed the past records and noted that the "patient did not manifest signs or symptoms consistent of a major psychiatric disorder other than his reported symptoms previously to coming to the hospital or the patient actually reporting symptoms usually with religious or spiritual content. . . " Dr. [redacted] did not note what past records she reviewed. He was discharged to outpatient care on the medications noted above.

Returning to outpatient care on February 26, 2001, [redacted] met with Dr. [redacted] who noted that the patient was "sleeping well and has his thoughts in order." He noted that Ms. [redacted] was compliant with medications. Dr. [redacted] also noted that Dr. [redacted] felt the medication helped with "his personality problems."

In a note dictated the same day. Dr. [redacted] stated: "His symptomatology was consistent with Hypomanic state. He indicated that he was experiencing auditory hallucinations, racing thoughts and his mood was somewhat elevated, easily agitated and extremely irritable. One is referred to the chart for a more complete description of client's history and issues related to his diagnosis." This note was dictated to indicated that Dr. [redacted] had read and approved [redacted] Treatment Plan, which diagnosed him as having Bipolar Disorder.

On April 26, 2001, [redacted] was seen by Dr. [redacted] who changed the diagnosis to History of Bipolar Affective Disorder. The interim clinical history described a visit to emergency services for suicidal ideation.

On May 24, 2001, Dr. [redacted] concluded that [redacted] was not taking his medication as directed. The serum Depakote level was low, and [redacted] stated that he was not taking Zyprexa frequently because of side-effects.

In July 2001, [redacted] presented to Danville Regional Emergency Department and was observed to be psychotic. During this emergency services visit and when he was next seen on October 18, 2001, [redacted] sold his belonging in Danville and moved to Pittsburgh to attend culinary school. He was not taking his medications, became depressed and hospitalized at Allegheny Hospital. He was discharged with a diagnosis of Bipolar Disorder, Mixed, and prescribed Risperdal and Depakote. Records from this hospitalization are not available.

During the October 18, 2001 outpatient visit, Dr. [redacted] noted medication compliance to be an issue and that [redacted] agreed with Dr. [redacted] statement that whenever [redacted]

[redacted] gets upset, he tells people he is manic in order to be hospitalized. Dr. [redacted] planned to stop [redacted]'s antipsychotic medication, but continue him on Depakote. Dr. [redacted] noted that [redacted] became "quite upset today when I told him that I believed that he did not have Bipolar Disorder and that I was stopping his medication."

[redacted] described this meeting as "very upsetting." He said that Dr. [redacted] would not give him another prescription for the Risperdal, did not instruct [redacted] to taper his medications, inform him of possible symptom recurrence. [redacted] had three days of Risperdal left. [redacted] felt that if he did not have a diagnosis, then why was he being treated by the medical profession for the last six years? He felt that the CSB had been "experimenting with me for the last six years."

The undersigned attempted to get further information about whether Dr. [redacted] tapered the Risperdal or whether it was abruptly stopped. Her response to this question relied on information included in the medical record. The conclusion reached by [redacted] was that because [redacted] was either not taking the Risperdal as director or that he had "run out" of the medication. Dr. [redacted] did not prescribe Risperdal. There is no documentation in the chart, information in the answering of this question, or in testimony by Dr [redacted] that he counseled the patient to take the medication regularly, not to discontinue the medication abruptly, and to taper the medication to determine whether it was necessary.

The meeting between Dr. [redacted] and [redacted] prompted intervention by a representative of NAMI who advocated for a treatment team meeting through the Office of Consumer Affairs to request a second opinion to clarify [redacted] diagnosis, ask for reassignment to another psychiatrist, and to discuss treatment goals and objectives.

The treatment team meeting was held on October 25, 2001. [redacted] characterized the meeting as adversarial. There were no formal minutes of this meeting made, or entries in the treatment record. [redacted] observed several staff members taking notes.

Should these become available for review, they would be important to review for additional information. Both [redacted] and Ms. [redacted], reported feeling frustrated by this encounter, which they reported as not including a discussion of treatment approaches, goals and objectives. Both left the meeting early. Minutes of the meeting were not made, but a note recording the meeting's occurrence and those in attendance was made in the chart.

A second opinion was provided. Dr. [redacted], also working at the Danville Community Services Board, performed her evaluation which was documented in her report dated October 23, 2001. Dr. [redacted] made a diagnosis of Alchol Abuse, and Personality Disorder, Not Otherwise Specified with Borderline, Antisocial, Histrionic, Schizotypal, and Paranoid Traits. Dr. [redacted] recommended that [redacted] be tapered off his medications, re-tested psychologically, and supported by therapy in the community. Dr. [redacted] described symptoms from previous hospitalizations: psychosis, agitation, hallucinations, delusions, paranoia, hyperactivity, hyper-religiosity, sleep and appetite disturbances, suicidal ideation, loose thought processes, excessive physical activity leading to injury, hyperfluent speech, racing thoughts, and poor psychosocial functioning. Dr. [redacted] stated that his past history did not support a diagnosis of Bipolar Disorder. It should be noted that resultant from seven of eight hospitalizations, a psychotic disorder diagnosis was made as the primary diagnosis. The hospitalization, during which Dr. [redacted] served as attending physician, was the hospitalization which concluded with no Axis I diagnosis. [redacted] in answering the question of how the decision was made to obtain a second opinion by [redacted], indicated that she was the only physician employed by "our Agency that [redacted] had not previously seen at DPCS."

[redacted] was to return to the Danville-Pittsylvania Clinic at the end of October 2001 to meet with a new attending psychiatrist. The day before the appointment, he was informed that he would be seeing Dr. [redacted] did not keep the appointment and was hospitalized following a recurrence of psychotic symptoms in November. [redacted] had been in contact with [redacted] before the hospitalization and she reported that [redacted]

[redacted] had been withdrawn, and reclusive in his room at his grandmother's house. She said he believed that the television was sending him messages, he was hearing the voice of a demon, and that his life was in danger. She believed him to be psychotic, and a danger to himself and he was hospitalized. He was eventually referred to the Piedmont Community Services Clinic.

In the psychiatric evaluation dated May 28, 2002,conducted by Dr. [redacted] at the Piedmont Community Services Clinic indicated that [redacted] was suffering from Schizoaffective Disorder, and was prescribed antipsychotic medications and mood stabilizers. He had been hospitalized and in a partial hospitalization program for about one month. He was responding well. He sought treatment at the Piedmont because, as Dr. [redacted] wrote: "he had a fall out with the Danville Clinic and he decided to come to this agency. Patient states that they don't believe at the Danville Clinic that he has schizoaffective disorder."

Dr. [redacted] reviewed the records of care for [redacted] for the Virginia Office for Protection and Advocacy, and concluded that the diagnostic conclusions of Drs. [redacted], and [redacted] were unexplainable and that the withdrawal of care was inappropriate. He further noted that the diagnosis of psychotic disorder was "amply" established in the medical records prior to Dr. [redacted] assuming care.

In the last year, [redacted] has been hospitalized four times. His psychotic diagnosis has not been questioned, and treatment planning has been developed to address compliance issues, mood and psychotic symptoms, and therapeutic alliance. He felt that the cause of his current difficulties was his treatment with Dr. [redacted] who he felt, "messed with my head" when "he told me I wasn't sick after I worked so long to accept my mental illness. I have a hard time trusting the mental health profession now."

OPINION: [redacted] has a clearly documented history of a psychotic illness. It is best characterized as Schizoaffective Disorder, Bipolar Type. There is also an Alcohol Abuse history

which is not uncommon with patients who have Schizoaffective Disorder. The alcohol/substance abuse diagnosis is an important part of the treatment considerations for [redacted]. His medications currently appear useful and appropriate. Clinical challenges will remain: medication compliance, abstinence from illicit substances, stress reduction, vocational rehabilitation, symptom identification, and early intervention.

There is not sufficient evidence in the medical record, or in the interviews with Drs. [redacted] and [redacted] which would warrant a change in diagnosis or treatment withdrawal. Predictably, [redacted] decompensated and required hospitalization when his medication was withdrawn. There was no documentation which indicated Dr. [redacted] counseled the patient regarding the consequences of stopping his antipsychotic medication. In fact, there was ample evidence in the medical record that non-compliance would cause a recurrence of symptoms. The medication should have been tapered, even if the patient had not been taking the medication regularly and [redacted] should have been instructed what to do should specific symptoms re-occur. The lack of diagnostic precision, disregard of well-documented past psychiatric history and wishes of the patient, indicate that basic standards of psychiatric diagnosis and treatment were not met.

This is not to say that a psychiatrist cannot question previous diagnoses. In fact, this is a useful position to take at times. Determining the presence of a psychiatric illness in a patient who is taking medications is complicated, but can be accomplished. First, the previous medical records must be consulted to determine the symptoms in question. Secondly, the treatment team and patients should be in agreement with a plan to withdraw medication and monitor symptoms. Target symptoms are identified, and medication is gradually weaned. Close follow-up is provided. Two to four weeks between visits is sufficient with concurrent psychotherapeutic support. Medication should not be stopped abruptly, as was effectively done in this case. This approach to diagnosis and treatment most likely led to [redacted] subsequent decompensation, and hospitalization. The distrust of the mental health system [redacted] was dependent upon left him with few options when symptoms of his illness began to emerge.

Additionally, when a second opinion was agreed upon by the treatment team, the facility should have scheduled this evaluation with a provider who had not seen the patient previously. This would have been ideally conducted with a psychiatrist outside of the institution seeking the second opinion. M[redacted] and his advocate at NAMI felt that [redacted]'s treatment planning process, and his relationship with Dr. [redacted] were adversarial. While these feelings are subjective, perceived adversarial therapeutic relationships, unless mitigated, are usually always destructive to the treatment of persons with severe and persistent mental illness.

An additional and related finding from this review is that there was no process for medical supervision of the psychiatrists employed at the Danville-Pittsylvania Community Services Board. A non-psychiatrist, non-medical doctor, cannot medically supervise a psychiatrist. Presenting the clinical questions Dr. [redacted] had to this medical supervisor would likely have resulted in a different outcome. Medical supervision requires the monitoring of quality care and regular evaluation of standard of care practices. While the Virginia Board of Medicine does not require that a licensed physician be supervised, the Community Services Board was employing Dr. [redacted] and other physicians and had the responsibility to monitor the proper credentialling and quality of care provided by these physicians. This is only accomplished with outside consultation and is a requirement of the Joint Commission on Accreditation of Health Care Organizations.

If there are any questions regarding this report or the conclusions stated herein, please contact me at the above address.

Ronald J. Koshes, M.D.
January 30, 2003

EXHIBIT C

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July 25, 2003

BY FACSIMILE and U.S. MAIL

William C. Tucker, Esq.
Harman, Claytor, Corrigan & Wellman
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Richmond, VA 23255

RE: DPCS v. VOPA, et al

Dear Mr. Tucker:

Enclosed is DPCS's Response and Statement of Its Opinion and Position. When VOPA's Report is published, this document should be published along with it.

Thank you for your attention to this matter.

Sincerely,

Ashley K. Geyer

ctc

Enclosure

xc: Mr. Lenard D. Lackey, Jr. (w/ enc.)

DANVILLE-PITTSYLVANIA COMMUNITY SERVICES (DPCS) RESPONSE TO VOPA REPORT AND STATEMENT OF ITS OPINION AND POSITION

CASE NO. 02-0354

Part I

VOPA's agent, Martinis, did not provide procedural due process in the investigation of DPCS's care of a consumer.

Part II

VOPA's finding of Neglect is a tainted indictment following an investigation which denied DPCS its rights to procedural due process. The violation of its due process rights has denied DPCS the ability and the opportunity to respond to many of the substantive allegations and findings of Neglect which are made in the VOPA Report.

Submitted by:

DANVILLE-PITTSYLVANIA COMMUNITY SERVICES

PART I: DPCS's right to procedural due process was violated by VOPA's employee, Jonathan G. Martinis ("Martinis").

This "investigation" was launched by VOPA in May 2002, commencing with Martinis' demand to interview DPCS staff. Martinis had informed DPCS's Executive Director of the complaint concerning Consumer in March 2002. Without hesitation, DPCS made its staff available to the interview schedule demanded by Martinis who originally scheduled interviews for June 20, 2002 and June 21, 2002. Arrangements were made to have DPCS staff available on those dates, including rescheduling dozens of consumer appointments previously scheduled for those dates. However, on June 12, 2002, Martinis notified DPCS that his schedule would not permit the interviews to proceed on those dates. DPCS accommodated his request to reschedule the interview dates for June 14 and July 11, 2002.

After the interviews, DPCS received a letter dated July 12, 2002, in which Martinis states, "Finally, as I promised yesterday, I will contact DPCSB in mid-August to inform you of my time frame for completion of the investigation. However, I think it is safe to say at this time that the investigation will not be complete at that time, as I will need to thoroughly review the tapes and transcripts from our interviews, and I do not expect to receive them before the end of this month." [redacted]

In November 2002, DPCS was asked to respond to a series of questions proposed by VOPA's expert witness. DPCS's response was delayed because VOPA did not provide an appropriate Release from the consumer allowing DPCS to release information to VOPA's expert. In December 2002, after finally receiving the appropriate Release, a detailed response to each of the questions was provided.

Many months passed without communication from Martinis or VOPA's expert. On June 5, 2003, DPCS received Martinis' proposed Report in which Martinis found Neglect. Thus, DPCS received the Report from Martinis more than six months after the date that all materials requested from DPCS were provided; more than one year after the investigation began; and more than 20 months after the incident which Martinis found to involve Neglect. It is noteworthy that DPCS was required by Martinis to respond within 13 business days of the Report or DPCS would relinquish its opportunity to have a response published with the Report. This is despite the fact that Martinis took over 18 months to write it.

An accusation of Neglect is a very serious matter. When the employee of an agency takes over a year to make a determination on an issue of Neglect, such a time frame is unacceptable as it effectively impairs the ability of those under investigation to defend themselves and to take meaningful corrective action. For example, the various Social Services Departments in Virginia are under an obligation to complete an investigation of alleged Neglect or abuse of a child or an adult in need of services within 45 days of receipt of the complaint. The purpose of the deadline for conducting and concluding the investigation is obviously intended to protect the rights of the alleged victim and the alleged perpetrator of the Neglect or abuse. The approach of Martinis in conducting and concluding the investigation concerning Consumer and DPCS represents a callous disregard for the best interests of Consumer and the rights of DPCS.

In summary, the lengthy unexcused delay in conducting and completing this investigation represented a denial of DPCS's right to procedural due process and fair treatment. For this reason alone, the Report should not be finalized, issued, or disseminated to the public. Yet, this particular denial of DPCS's rights of procedural due process is but one on a long list of due process infractions which are described in the following paragraphs.

On May 28, 2002, DPCS's Executive Director wrote a letter requesting a copy of internal policies and procedures that VOPA (formerly DRVD) follows in conducting investigations. He requested this information so that DPCS would be informed as to its rights and responsibilities. DPCS received correspondence from Martinis dated June 3, 2002, indicating that he had enclosed the DRVD Investigation Manual (the "Manual"). In the second paragraph of the letter, he stated, "With regard to your request for 'internal policies and procedures that DRVD follows in conducting investigations', I enclose a document from 1997 entitled 'Investigation Manual'". DPCS expected Martinis to follow the guidelines of the Manual he provided. Regrettably, he ignored many of the most important guidelines and denied DPCS its right of due process. For example:

A) While the organization was the "Department for Rights of Virginians with Disabilities", during the first part of this investigation, Martinis failed to comply with Virginia Code § 51.5-37(4). Then, when the organization became the "Virginia Office for Protection and Advocacy", as the investigation continued, Martinis failed to comply with Virginia Code § 51.5-39.4(2). Releasing the Report to the public, pursuant to Virginia Code § 51.5-39.8(c)(1), is permissible only when VOPA has complied with the statutes above and with its own protocol, i.e., the Manual.

These provisions of the Virginia Code specifically required DRVD to "employ mediation procedures to the maximum extent possible to resolve complaints concerning violations of rights of persons with disabilities when those rights are related to such disabilities. When such procedures fail, the department shall have the authority to pursue legal, administrative and other appropriate remedies to protect the rights of persons with disabilities...". § 51.5-37(4) of the Virginia Code. These statutory provisions required VOPA to "exhaust in a timely manner all appropriate administrative remedies to resolve complaints concerning violations of rights of persons with disabilities, when those rights are related to such disabilities. When such procedures fail or if, in pursuing administrative remedies, the office determines that any matter with respect to an individual with a disability will not be resolved in a reasonable time, the office shall have the authority to pursue legal and other alternative remedies to protect the rights of such persons." § 51.5-39.4(2) of the Virginia Code.

At no time did Martinis offer mediation or administrative remedies to DPCS. Rather, he has skipped these procedural safeguards and announced his intention to publicly release the Report. Martinis also conducted the investigation in violation of federal regulations including, without limitation, 42 C.F.R. 51.31(b) and 42 C.F.R. 51.32(a)(b).

B) The policy and procedure set forth in the Manual make it clear that "the Managing Attorney will assign an advocate or advocates to conduct the investigation." This advocate would then consult with the Managing Attorney regarding information gathered. The advocate would be required to update the

Managing Attorney on the progress of the investigation with regular, frequent, and written reports. A brief summary of the status of the investigation would be provided by the advocate to the Managing Attorney in the advocate's monthly inventory report. It should be noted that, in this case involving DPCS, Martinis served as both advocate and Managing Attorney. Martinis conducted the interviews and handled the entire investigation while also purporting to supervise himself in his capacity as Managing Attorney. Ironically, this attempt by Martinis to supervise himself is precisely what he determined to involve Neglect on the part of DPCS for not having independently supervised it's employee physician.

C) One of the protocols indicated in Chapter 1 of the Manual, page 3, is that "no investigation will be made of complaints of abuse or Neglect, including complaints of abuse and Neglect which result in death, if the complaint is received by DRVD more than six months following the incident giving rise the complaint." This language suggests that DPCS should be informed regarding the nature and date of the incident, which is being investigated. On more than one occasion, DPCS asked Martinis for documentation as to the nature and date of the complaint. This was requested via telephone by the Executive Director of DPCS, in March of 2002. Then reiterated in a letter dated May 28, 2002 the following request was made, "As I stated in today's conversation, we would like to have the specific event/action that occurred in this case that you are investigating as possible abuse or Neglect of [Consumer]." Martinis responded to that letter request with a letter dated May 31, 2002, stating under item (2) "the purpose of this investigation will be to determine whether [Consumer] was the victim of abuse or Neglect as those terms are defined in the Virginia and Federal law cited above. As I have previously stated, we have received a complaint regarding the care and treatment given to [Consumer]. In the investigation I will be reviewing the care and treatment given to [Consumer], to determine whether it was abusive or neglectful." Martinis made no attempt to identify a specific event/action before commencing the interviews of DPCS staff.

In correspondence dated July 26, 2002, to Martinis from DPCS, "...You may recall that upon learning of VOPA's investigation we requested a copy of the initial consumer complaint and the specifics of the charge of abuse or Neglect. We are officially requesting copies of interview transcripts, the initial consumer complaint in the specific charge of abuse or Neglect, so that we will be as informed as you indicated we should be." The letter goes on further to point out that if the focal point and primary goal of the VOPA office is to "affect systemic change (as stated in the manual), ...it appears to us that providing this agency with the materials requested above, can only aid in achieving the primary goal as stated per VOPA. Theoretically, these materials could only aid DPCS in bringing about the systemic change that your organization publicizes as its primary goal." Martinis refused the request, insisting that DPCS blindly participate in the investigation of an unidentified incident involving abuse or Neglect.

D) In Chapter 2 of the Manual, under the title "Plan the Investigation", the investigator was required to develop a written plan for the investigation. Required under Roman numeral II, "as you start the investigation you should develop a written plan for the investigation containing: 1) the issues the investigation will address; 2) the goals and objectives of the investigation; 2) the hypotheses for what happened, which the investigation will prove or disprove; 3) a list of

documents of documents to be collected and a time line for collecting them; 4) a list of witnesses and a time line for interviewing them; and 5) a complete time line for the investigation, including a target completion date for both the investigation and the report. The investigation plan is a live instrument which will be reviewed regularly and rewritten as necessary." When asked to disclose this written plan, Martinis indicated that he never uses written notes prior to conducting his investigation nor does he ever compile a list of questions in advance of the interviews taking place. In addition, Martinis wrote DPCS Executive Director a letter dated May 31, 2002. Under (5) of that letter, he stated, "I will not forward to you an outline of the questions I intend to ask in our interviews. I answer thus for two main reasons, first and foremost, I do not have such an outline, and secondly, even if I did have such an outline, our investigation materials are confidential pursuant to Virginia and Federal Law..." Martinis was very clear about the fact that he did not have a written plan and could not disclose his plan to DPCS because it did not exist.

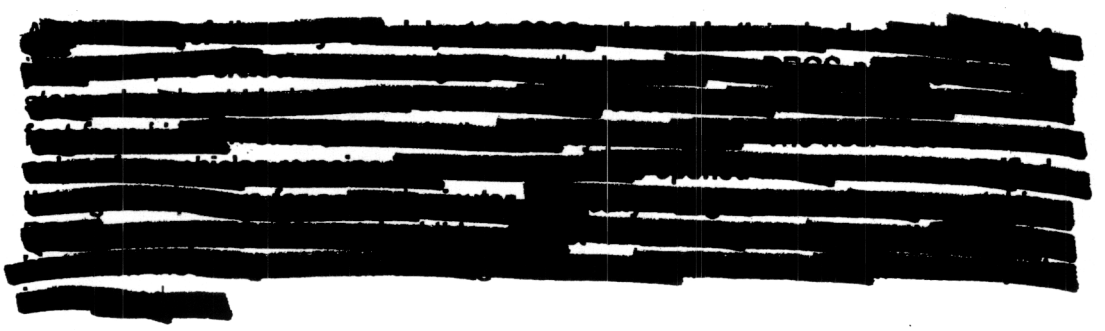
E) On the scheduled date and time that the interviews were to take place on June 14, 2002, DPCS staff members were ready and waiting for Martinis' arrival. When he was 45 minutes late past his scheduled arrival time, the DRVD office was called regarding Martinis' whereabouts. The DRVD staff indicated that they would attempt to reach Martinis by phone. A few moments later, DPCS received a call back from the DRVD office indicating that Martinis had been reached on his cell phone in route and that he expected to arrive at the DPCS offices within 15 minutes. It should be noted that clearly Martinis knew he would be over an hour late for the appointment and that he had a cell phone with him with active cell phone service. Martinis could have alerted DPCS that he was running late; however, no such phone call was received. [redacted]

F) Throughout the investigation, Martinis appeared to assume the role of detective, prosecuting attorney, judge, and jury. With his intention to issue the Report, he now apparently proposes to assume the role of executioner as well. This scenario provides no semblance of due process. It is DPCS's belief that Martinis had constructed an agenda for himself, which involved proving DPCS's Neglect rather than investigating the possibility of Neglect. He focused his questions narrowly on staff responses, which would support his mission. As evidenced by the transcript and tape, on more than one occasion, Martinis dogmatically queried staff with a variety of questions that appeared to have only one response rather than asking open-ended, information-gathering type questions. This investigation at no time appeared to be a fact-finding mission; rather, Martinis behaved like a lawyer in a courtroom conducting cross-examination of an enemy/hostile witness. This will be apparent in the auditory tapes and transcript of the interviews but would be even more obvious if the interviews had been videotaped.

G) Especially noteworthy is the tape and transcript of Martinis' interview of the DPCS psychiatrist employee, Dr. 1. DPCS contends that Martinis exhibited a hostile and disrespectful attitude towards Dr. 1, treating him with the utmost disdain. For example, when Dr. 1 refused to answer "yes" to some of Martinis'

questions, Martinis retorted by saying, "I'll try and send you to bed without any milk." He was asked by DPCS attorney to repeat his comment, and Martinis said again, "I'm going to try to keep him from going to bed without any milk, because he refused to answer, and I think we're being more than a bit childish right now." Dr. 1 said, "Excuse me?" Martinis responded, "I think you're being childish right now." See pages 45 through 53 of the transcript of the interview tapes.

H) On page 15 of the Manual, there is a discussion as to how the investigator should conduct himself through the process. For example, the "interviewer maintains a cool, calm demeanor, and projects sincerity and interest in the witness. Direct eye contact and good posture convey a professional objectivity to the witness. Try to maintain your focus on the witness and not on taking notes... The best interview questions are short and to the point. Questions should be easy to understand." In the lengthy transcript of the interviews, which Martinis conducted, there are dozens of examples of Martinis demonstrating either an inability or unwillingness to ask questions that were short, to the point, or easy to understand. Interestingly there is a directive with regards to how to handle witnesses who are considered either difficult or uncooperative. It states that the witness "does not necessarily have something to hide" and the suggestion of the interviewer's conduct to be "take the time to build rapport early in the interview, or to identify why the witness is being difficult." It also suggests, on page 16, that the interviewer "ask your question, maintain eye contact, and wait for the witness to answer. Do not fill the silences. Leave the great, quiet spaces for the witness to fill." The tape recordings and transcripts of the interview contain dozens of examples where Martinis did not allow an individual to answer in the manner in which they preferred. In addition, there were a number of times while interviewing staff when Martinis would put his feet on the table, with his hands behind his head, and rock his chair back and forth. Such a demeanor exhibited a complete lack of respect for DPCS staff who had voluntarily submitted to be interviewed by him.

I) 

J) On page 17 of the Manual, the third paragraph states that "your reasons for determining that one person's statement is more reliable than another person's statement must appear in your report." The Report makes no attempt to substantiate why the opinion of VOPA's expert was considered more valuable than the opinion of the DPCS psychiatrist. There is no indication that VOPA's expert had a face-to-face evaluation and/or interview with Consumer or that he provided ongoing services for Consumer.

K) On page 3 of the Report under the heading "Methodology of Investigation", Item C indicates that VOPA "engaged two doctors as experts to review [Consumer's] care." Since there is only one doctor disclosed as an expert in the Report, any opinion of the anonymous expert should be disregarded or seriously questioned. Clearly, DPCS lacks the ability to respond to an expert opinion when the expert remains anonymous and his opinion is selectively quoted in the Report. Ironically, the Report includes a directive that DPCS see that each and every treatment decision and diagnosis made by any physician is reviewed and confirmed by a second outside physician. Yet, there is no indication that the opinion of VOPA's expert was reviewed at all, except by Martinis who, while assuming every other role in the process, did not claim to possess a medical degree which would satisfy such a supervisory requirement.

In summary, it is the opinion of DPCS that VOPA's investigative procedures and protocol for conducting the investigation were not followed. It also appeared to DPCS that the conduct of the investigator lacked professionalism and was, at times, even hostile. For these reasons, and others referred to in Part II, DPCS has serious concerns about the product of the investigation, *i.e.*, the Report.

PART II: VOPA's finding of Neglect is a tainted indictment following an investigation which denied DPCS its rights to procedural due process. The violation of its due process rights has denied DPCS the ability and the opportunity to respond to many of the substantive allegations and findings of Neglect which are made in the VOPA Report.

The findings of Neglect made by Martinis are as follows:

1. Dr. 1 abruptly discontinued Consumer's antipsychotic medications;
2. Dr. 1 erroneously diagnosed Consumer with a Personality Disorder rather than a Major Mental Illness[1];
3. DPCS failed to provide an appropriate independent second opinion; and
4. DPCS failed to have in place (a) a system of "peer review"; (b) a disciplinary procedure for physicians who are guilty of Neglect; and (c) a system, headed by a medical professional, who supervises diagnostic and treatment decisions of DPCS psychiatrists.

Items 1 and 2

Martinis, as VOPA's agent, denied DPCS due process with respect to the length of the investigation and the failure to follow state and federal law, regulations, and VOPA's own internal investigative manual. See Part I. These violations of due process have effectively denied DPCS the ability and opportunity to respond to the findings of Neglect numbered 1 and 2 above. Several months before Martinis released the draft of his Report, thereby finally informing DPCS of the specific charge of Neglect that had been investigated, Dr. 1 had left the employment of DPCS and relocated to another state. To date, DPCS has not received input from Dr. 1 as to the allegations of Neglect cited in paragraphs 1 and 2 above. The very nature of these allegations of Neglect highlight the importance of the investigation proceeding promptly, according to the rules, such that DPCS would not be in the position of attempting to defend itself, and its former employee, under these circumstances.

Item 3

While impaired by the violation of its due process rights and without waiving its position that the Martinis Report should be retracted or significantly revised, DPCS provides the following response concerning this allegation of Neglect.

Martinis found Neglect on the part of DPCS for not arranging for a "truly independent second opinion" when Consumer indicated his displeasure with Dr. 1. DPCS contends that Consumer did receive a second opinion which was appropriate under the circumstances. DPCS is not aware of any CSB that provides outside second opinions for consumers who choose the CSB for services. At any time during the course of his treatment, should a consumer be interested in receiving services or a second opinion or outside opinion from a physician who is not employed by DPCS, he may do so. The consumer would receive linking services from his case manager if he indicated to the case manager that he wanted to be referred. However, it would be incumbent upon that consumer to make arrangements for the

[1] See Exhibit A attached hereto regarding Martinis' suggestion that Dr. 1 and DPCS acted unlawfully.

payment of that second opinion. At DPCS, there is no requirement that consumers receive their physician/psychiatric services from a DPCS psychiatrist. In fact, many DPCS consumers are treated by private psychiatrists. Consumer could have exercised that option at any time that he chose to have a "truly independent opinion", as well as treatment follow-up and prescriptive services provided by any physician of his choosing, and yet he could contemporaneously continue to receive other DPCS services that were satisfactory to him.

Following the session with Dr. 1 on October 18, 2001, Consumer's first request was that he not receive further services from Dr. 1 and that he be placed with a new physician. Consumer was not interested in a second opinion but, rather, a new doctor. In communications with Consumer that followed, a DPCS employee did describe the arrangement for Consumer to see Dr. 2 as a "second opinion". However, Consumer was still clearly approaching the appointment as the first appointment with a new physician. For these reasons, Dr. 2 was an appropriate choice for the appointment that Consumer received on October 23, 2001. At the time, there were only three psychiatrists on DPCS's staff. Consumer had already rejected Dr. 3 in favor of Dr. 1. This left Dr. 2 as the lone staff psychiatrist who was in a position to take Consumer as a new patient. Consumer knew well in advance of the appointment that he was being offered an appointment with Dr. 2 as a change from Dr. 1. Consumer was asked if that change was what he wanted to do, and he confirmed that it was. Consumer knew that he had received services from Dr. 2 while a patient at a local hospital which is not affiliated with DPCS. Therefore, DPCS was arranging for this appointment with Dr. 2 in an effort to comply with Consumer's specific request for a different doctor and to hopefully place him with a physician who would not be objectionable. While the appointment with Dr. 2 was not intended to be a second opinion in the pure sense of the term, the process of moving Consumer to a new physician would obviously involve an independent assessment by Dr. 2. Consumer received that independent assessment.

Therefore, DPCS disagrees with the Martinis finding that DPCS did not provide adequate and appropriate medical supervision when it failed to afford Consumer a "truly independent second opinion". The referral to Dr. 2 was appropriate under the circumstances. DPCS properly arranged for Dr. 2 to review the case. Consumer did not request, and DPCS did not purport to afford, a "truly independent second opinion".

Item 4(a)

DPCS already has in place a system which facilitates peer review. While there may be room for improvement in any system designed to review, question and correct diagnostic and treatment decisions made for the benefit of the consumers of CSBs in Virginia, including the system at DPCS, the finding and recommendation by Martinis suggests that DPCS completely ignores this basic concept of healthcare. That is not the case. In October 2001 and today, DPCS expects its physician, nurses and case managers to freely communicate with one another regarding treatment plans, medication, and other matters affecting a consumer's well-being. Nurses are comfortable discussing concerns with physicians, case managers are comfortable discussing concerns with nurses or physicians, etc.

Therefore, DPCS disagrees with the conclusion by Martinis that the "peer review" system at DPCS is non-existent and that DPCS is therefore guilty of Neglect. On the other hand, DPCS would be receptive to constructive and specific recommendation as to how its system may be improved.

Item 4(b)

DPCS also has in place a system of discipline for physicians who are guilty of Neglect. Dr. 1 and other DPCS staff physicians are bound by the terms of their contract with DPCS which contains Standards of Conduct to which they must adhere. Therefore, there are appropriate disciplinary measures in place to deal with physicians who violate such Standards.

Item 4(c)

VOPA's recommendation that DPCS and all other CSBs utilize a Medical Director to oversee diagnostic and treatment decisions by physicians is neither practical nor required. VOPA's expert appropriately observes that the Virginia Board of Medicine does not require that a licensed physician be supervised. However, he goes on to mention that monitoring the quality of care provided by DPCS physicians is only accomplished by outside consultation and is a requirement of the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). He is in error on this point. While JCAHO may require outside consultation in those organizations which it governs, JCAHO does not govern DPCS or DPCS's staff physicians.

To employ a physician to review, question and correct each diagnostic and treatment decision would require the employment of at least one full-time psychiatrist to provide that review requirement. This suggestion for the mental health system, both for public and private group practices and for individual practitioners in private practice, may be seen as an admirable goal but a totally impractical one. It is a goal that is not required and is seldom reached in either the public or private sector.

Martinis recommends that the system must be headed by a psychiatrist who has the power to oversee and correct diagnostic and treatment decisions. "To create and implement a system that appropriately supervises its doctors and the system be headed by a medical profession" infers that the physicians must always report to another physician, and the most senior physician in the chain of command must only supervise and not provide any direct services himself.

Finally, it is not possible to review every treatment decision that is made by all of the clinical staff employed at the Agency. Frankly, in the absence of a large infusion of funds to cover the cost of additional psychiatric services, DPCS would have to reduce service capacity in order to provide the recommended supervision that Martinis has suggested. His recommendations are centered around a costly oversight system which is impossible to achieve without a significant infusion of funding or a sacrifice of a multitude of consumers who would be left without services due to the reallocation of the existing dollars to pay for such medical supervision. Furthermore, the Martinis-recommended oversight system is not a standard that guides the practice of medicine.

EXHIBIT A

In the footnote on page 33 of his Report, Martinis implies that Dr. 1 inappropriately signed a treatment authorization form for Consumer. Martinis suggests this was done in order for DPCS to bill Medicaid for services. It is significant to note that there is no diagnosis criteria required for outpatient clinic option billing for services to Medicaid. The physician signature is only required to demonstrate that the physician agrees that outpatient counseling services are needed. In the investigative interview, DPCS informed Martinis that no diagnostic criteria was required in order to bill Medicaid for Outpatient Clinic Option Services.